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HEALTH QUESTIONNAIRE

Name: _____ Social Security #:_____

Age:_____ Sex:_____ Height:_____ Weight: _____ Date of Birth: _____/_____/__ _____

Reason for today's visit: _____
_____
_____

Please circle Yes or No and explain as necessary.

1. Are you in good health? . . . . . Yes No
2. Has there been any change in your health within the last year? . . . Yes No
   If yes, please explain: _____
3. Are you now under or have you ever been under the care of a physician? . . Yes No
   If yes: Physician's name: _____ Date:_____
   Reason: _____
   _____
4. Have you ever had any serious illness? . . . . . Yes No
   If yes, please list illness and date of diagnosis and treatment: _____
   _____
   _____
5. Have you ever had surgery? . . . . . Yes No
   If yes, please list the surgeries and dates: _____
   _____
   _____
6. Have you ever been hospitalized? . . . . . Yes No
   If yes, please explain and give dates: _____
   _____
   _____
7. Do you have, or have you had ***heart, other cardiovascular problems, or chest pain***?
   a. Heart murmur or heart valve defect . . . . . Yes No
   b. Heart valve replacement . . . . . Yes No
   c. Rheumatic fever or rheumatic heart disease . . . . Yes No
   d. Congenital heart defect or problems . . . . . Yes No
   e. Do you have a pacemaker . . . . . Yes No
   f. Heart attack . . . . . Yes No
   g. High blood pressure . . . . . Yes No
   h. Low blood pressure . . . . . Yes No
   i. Irregular or rapid heart beat . . . . . Yes No
   j. Chest pain . . . . . Yes No
   k. Shortness of breath . . . . . Yes No
   l. CHF/ Congestive heart failure . . . . . Yes No
   m. Swollen ankles or hands . . . . . Yes No
   n. Artificial joints or prosthetics . . . . . Yes No
   o. Other heart, other cardiovascular problems, or chest pain (please explain): _____
   _____
8. Do you have, or have you had ***lung problems***?
   a. Asthma . . . . . Yes No
   b. Bronchitis, tuberculosis, or emphysema . . . . . Yes No
   c. Other lung problems (please explain): _____
9. Do you have, or have you had ***liver problems***?
   a. Hepatitis or yellow jaundice . . . . . Yes No
   b. Other liver problems (please explain): _____
10. Do you have, or have you had ***kidney problems***?
    a. Frequent kidney infections . . . . . Yes No

b. Frequent urinary tract infections or burning during urination . . Yes No
c. Frequent urination, or blood in the urine . . . . . Yes No
d. Other kidney problems (please explain): _____

11. Do you have, or have you had ***stomach or intestinal problems***?
a. Ulcers, blood in stool, black stools, or vomiting blood . . . Yes No
b. Other stomach or intestinal problems (please explain): _____
_____

12. Do you have, or have you had ***blood problems***?
a. Anemia . . . . . Yes No
b. Bleeding problems . . . . . Yes No
c. Bruise easily . . . . . Yes No

13. Do you have or have you had ***endocrine problems***?
a. Thyroid problems . . . . . Yes No
If yes, what type? _____
b. Cortisone or steroid treatments . . . . . Yes No
c. Pheochromocytoma . . . . . Yes No
d. Diabetes . . . . . Yes No
e. Hypoglycemia or low blood sugar. . . . . Yes No

14. Stroke? If yes, when: _____. Yes No
15. Fainting spells, seizures, or epilepsy? . . . . . Yes No
16. Have you been diagnosed with glaucoma? . . . . . Yes No
17. Have you experienced tonsillitis? . . . . . Yes No
18. Sinus trouble, hay fever, hives, or skin rash? . . . . . Yes No
19. Have you had, or do you have a serious viral illness? . . . . Yes No
20. Arthritis or inflammatory rheumatism? . . . . . Yes No
21. Gout? . . . . . Yes No
22. Persistent cough or coughing up blood? . . . . . Yes No
23. Sexually transmitted disease.? If yes, when treated _____ Yes No
24. Do you have an autoimmune disorder? . . . . . Yes No
25. Do you have a history of significant snoring or sleep apnea/OSA? . . . Yes No
26 Have you ever had any problem associated with tooth removal or other oral surgery? . Yes No
27. Have you had any head, neck, or jaw injuries? . . . . . Yes No
28. Have you experienced any problems in your jaw, such as:
a. Clicking, popping, or grinding? . . . . . Yes No
b. Pain in the joint, ear, or side of face? . . . . . Yes No
c. Difficulty opening or closing your mouth, or chewing? . . . Yes No

29. List all surgeries and x-ray or radiation treatment for a tumor/cancer: _____
_____

30. Please list any other diseases, illnesses, or health problems not covered above: _____
_____

31. Please circle any of the following drugs you have taken in the last year:

Anticoagulants (blood thinners)	Birth control pills	Aspirin
Blood pressure medicine	Cortisone (steroids)	Antidepressants
Insulin or diabetes drugs	Digitalis, Nitroglycerin, or other heart medication	Tranquilizers or sedatives

32. Have you **ever** taken/been given Bisphosphonates (these drugs are used to treat osteoporosis and some cancers) including Aredia, Zometa, Boniva, Fosamax , Actonel, alendronate, ibandronate, risedronate, pamidronate, or zoledronic acid? Yes No

33. List all medications (and the dosages) and herbal substances that you are currently taking: _____
_____
_____
_____

34. List all medications (and the dosages) that you have taken within the past 12 months but are not now taking:
_____
_____

35. Are you allergic to, had a bad reaction to, or has a doctor told you not to take any of the following:

a. Local anesthetics	Yes	No	g. Penicillin or clindamycin	Yes	No
b. Aspirin or ibuprofen	Yes	No	h. other antibiotics _____	Yes	No
c. Iodine	Yes	No	i. Codeine,Vicodin, Fentanyl, Demerol,		
d. Latex or rubber products	Yes	No	other narcotics or pain medication	Yes	No
e. Steroids	Yes	No	j. Brevital or Ketamine	Yes	No
f. Sulfa drugs	Yes	No	k Versed or Valium	Yes	No

36. Do you have, or have you had any other ***allergies, including allergies to medicines or drugs***? Yes No
    If yes, please explain: _____
    _____
37. Do you now or have you ever smoked? . . . . . Yes No
    If yes, do you smoke now? . . . . . Yes No
    If you quit smoking, when did you quit? _____
    How many years have you or did you smoke? _____
    How many packs per day do you or did you smoke on average? _____
38. Do you now or have you ever used smokeless tobacco? .. . . . Yes No
    If yes, do you use smokeless tobacco now? . . . . . Yes No
    If you quit, when did you quit? _____
    How many years have you or did you use smokeless tobacco?_____
39. Do you drink alcohol? . . . . . Yes No
    How much per day? _____
    How many years? _____
40. Have you ever used illicit drugs? . . . . . Yes No
    If yes, which ones? _____
41. Do you wear contact lenses? . . . . . Yes No
42. Do you wear removable dental appliances? . . . . . Yes No
43. ***Women:*** Are you pregnant, or is there any chance that you might you be pregnant? . Yes No
44. ***Women:*** Are you nursing? . . . . . Yes No
45. Do you wish to talk about anything privately with the doctor? . . . Yes No
46. Is there anything else you wish to tell us including further explanation of anything above? Yes No
    _____
    _____
    _____

I certify that I have read and understand the above. I will not hold my oral and maxillofacial surgeon, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient (Parent or Guardian if patient is a minor) *Date*

_____ _____
Signature of Doctor *Date*

Update (subsequent visits only)

I certify that I have reviewed the above medical history.

❒ There have been no changes since the above date.

❒ Please note the following changes in my medical history._____

_____

_____

_____ _____
Signature of Patient, Parent or Guardian *Date*

_____ _____
Signature of Doctor *Date*