ORAL SURGERY
CONFIDENTIAL HEALTH QUESTIONNAIRE

Some general information concerning your medical and dental history is essential for proper oral surgical diagnosis, treatment and record maintenance. Please fill out the following to the best of your knowledge. If you have any questions, we will be happy to assist you.

Name _____ Date of Birth _____/_____/_____

Emergency Contact _____Phone (____) _____

General Dentist _____Phone (____) _____

Email Address _____

My problem or reason for seeking treatment is:

❒ General dental care ❒ Dental Implants ❒ Extractions ❒ Impacted teeth
❒ Fractured Jaw ❒ Oral Lesions ❒ Cysts or Tumors ❒ Facial Pain
❒ Snoring & Sleep apnea ❒ Apicoectomy ❒ Orthodontics ❒ Jaw Surgery
❒ Other _____

1. Have you ever had a serious illness or major operation? ❒ YES ❒ NO
   If yes, Please describe: _____
2. Have you ever had General Anesthesia? ❒ YES ❒ NO
   If yes, Please describe: _____
3. Are you now under the care of a physician? If yes, what is the condition being Treated? ❒ YES ❒ NO
   _____
4. Do you currently have a persistent cough? If yes, duration:_____ ❒ YES ❒ NO
5a. Are you presently taking any medications or drugs? ❒ YES ❒ NO
   If yes, please list them: _____
5b. Are you <u>presently</u> taking any of the following medication?
   ❒ Aspirin ❒ Vitamin E ❒ Coumadin (blood thinner) ❒ Herbal Supplement
   ❒ Fosamax ❒ Bisphosphonates ❒ Didronel ❒ Aredia ❒ Actonel ❒ Zometa ❒ Boniva
   ❒ Bonefos ❒ Loron ❒ Skelid ❒ Nerixia ❒ Aclasta ❒ Reclast ❒ Atelvia
6. Have you ever had an **allergic reaction** to medication or anesthesia? ❒ YES ❒ NO
   If yes, please describe: _____
7. Have you ever required a blood transfusion or have bleeding disorders? ❒ YES ❒ NO
8. Have you ever been in contact with any individual having Hepatitis, Tuberculosis (T.B.), Or AIDS? ❒ YES ❒ NO
9. Are you addicted to or recovering from any drug or alcohol addiction? ❒ YES ❒ NO
10. Are you wearing contact lenses? If yes, remove your contacts prior to surgery ❒ YES ❒ NO
11. Do you have any visual or hearing problems? Or any other disabilities, Which we should consider in planning your oral surgical treatment? ❒ YES ❒ NO
    If yes, Please describe: _____

Primary Care Physician_____Phone_____
Street_____City_____State_____

OVER PLEASE

12. Do you have a history of any of the following? **(Please check yes or no-do not leave any blank)**

	Yes	No		Yes	No
High blood pressure / Hypertension			Anemia		
Heart murmur			Bleeding disorder		
Rheumatic fever / Rheumatic Heart Disease			Kidney Disease		
Mitral valve prolapse			Dialysis		
Angina Pectoris / Chest pain upon exertion			Organ transplant		
Heart or bypass surgery			Cancer		
Heart Disease			Radiation therapy		
Prosthetic (artificial) heart valve			Chemotherapy		
Irregular / Rapid heart beat			Epilepsy / Seizure / Convulsion		
Pacemaker / Implanted defibrillator			Stomach ulcer / Hyper-acidity		
Heart Attack			Colitis / Intestinal problem		
Stroke / TIA			Arthritis and/or painful swollen joints		
Sleep Apnea			Prosthetic (artificial) joints		
Emphysema / Respiratory problems			Jaw joint pain (TMJ) or clicking/popping		
Asthma or Hay fever			Sexually transmitted disease (STD)		
Diabetes			AIDS / HIV		
Hypoglycemia			Tuberculosis (TB)		
Thyroid disease			Frequent or recurring mouth sores		
Persistent swollen neck glands			Hepatitis / Jaundice / Liver Disease		
Psychiatric Treatment			Allergy to latex		
Osteoporosis			Bone cancer		
Bone Disease			Paget's disease		
Osteogenesis imperfecta			Myeloma / Multiple Myeloma		

If you answered "yes" to any of the above questions, please explain below and if there is any other significant information concerning your past medical or dental history, please describe and discuss it with your doctor:

_____

13. Have you ever taken/used or currently take/use any of the following?

❒ Appetite Suppressant (such as Fen-Phen) ❒ Tobacco ❒ Alcohol ❒ Recreational Drugs

14. Do you have any other medical problems not listed above?_____

_____

For women only: a. Are you pregnant or trying to become pregnant? ❒ YES ❒ NO

b. Are you taking birth control pills or Hormones? ❒ YES ❒ NO

(Please note any medications prescribed, for your oral surgical care may interfere with the action of birth control pills.)

Permission is hereby granted to the staff of this office for such procedures and anesthesia as may be necessary for the care of the undersigned patient. Permission is granted to release my medical-surgical records to my primary Dentist or Physician. Permission is also granted to take x-rays, images, or photographs that could be used for diagnostic or educational purposes. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set fourth above have been answered to my satisfaction. I will not hold my dentist responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ **Date** _____

Legally responsible person if patient cannot sign or is a minor (under 18) _____

Relationship of the above to the patient _____

Doctor's Comments: _____

_____

_____

Doctor's Signature_____**Date** _____