ORAL SURGERY HEALTH QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS AND FILL IN THE BLANK SPACES WHERE INDICATED. ANSWERS TO ALL THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you had food or drink today? Yes No

2. Are you in good health? Yes No

3. Your last physical exam was on _____

4. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated?
   _____

5. Name and Telephone number of physician? _____
   _____
   _____

6. Have you ever had any serious illness, operation or been hospitalized? Yes No

7. Do you drink alcoholic beverages? Yes No

8. Please answer yes or no to all items below. Have you had any one of the following illnesses:

	Yes	No
Aids	___	___
Allergies	___	___
Anemia	___	___
Angina	___	___
Arthritis	___	___
Artificial Joint Replacement		___
___		
Asthma	___	___
Cancer	___	___
Diabetes	___	___
Emphysema	___	___
Epilepsy	___	___
Fainting	___	___
Glaucoma	___	___
Heart Attack	___	___
Heart Bypass	___	___
Heart Problem	___	___
Hepatitis	___	___
High Blood Pressure	___	___
HIV Positive	___	___
Kidney Disease	___	___
Liver Problem	___	___
Low Blood Pressure		___
___		
Lung Disease	___	___
Rheumatic Fever	___	___
Sinus Problem	___	___
Stroke	___	___
Thyroid	___	___
Tuberculosis	___	___
Venereal Disease	___	___

Other _____

9. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No

10. Do you have any blood disorder such as anemia? Yes No

11. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or lips? Yes No

12. Are you taking any drug or medicine? Yes No
    If yes, what medication? _____

13. Are you taking any of the following?
    a. Antibiotics or sulfa drugs Yes No
    b. Anticoagulants (blood thinners) Yes No
    c. Medicine for high blood pressure Yes No
    d. Cortisone (steroids) Yes No
    e. Tranquilizers Yes No
    f. Aspirin Yes No
    g. Insulin, Tolbutamid Yes No
    h. Digitalis or drugs for heart problems Yes No
    i. Nitroglycerin Yes No
    j. Other _____

14. Are you allergic or have you reacted adversely to:
    a. Iodine Yes No
    b. Local anesthetic Yes No
    c. Penicillin or other antibiotics Yes No
    d. Sulfa drugs Yes No
    e. Barbituates, sedatives, sleeping pills Yes No
    f. Aspirin Yes No
    g. Other _____

15. Have you had any adverse reaction associated with previous dental treatment? If so, explain: _____
    _____

16. Have you had any adverse reaction associated with previous medical problems? If so, explain: _____
    _____

17. Are you pregnant? Yes No

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware.

_____ _____
Patient Signature Date

I have reviewed the health history form above.

_____ _____
Doctor Signature Date