Oral Surgery Health Questionnaire

Patient Name: _____ **Birth Date:** _____ **Chart Number:** _____

Age: _____ Sex: _____ Height: _____ Weight: _____ BMI:_____ BP:_____

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES. ANSWERS ARE FOR OUR RECORDS ONLY AND ARE 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 under the care of a physician? ---------- Yes No
   If so, what condition(s)? _____
   Name & Number _____
5. Have you had any serious illness, operation or been hospitalized? Specify: _____ Yes No
6. Have you had abnormal bleeding or bruising associated with previous extractions, surgery or trauma? ---------- Yes No
7. Have you had a blood transfusion? Why?_____ Yes No
8. List ALL Medications, Vitamins & Supplements_____
   _____
9. Do you drink alcoholic beverages? How much? How often?_____ Yes No
10. Do you smoke cigarettes, marijuana? How much? Last used?_____ Yes No
11. Have you ever used recreational drugs (ex. Cocaine, Meth)?-----Specify _____ Last used? _____ Yes No
12. Do you use CBD oil &/or any other legal or illegal synthetic &/or natural medications? Specify: _____ Yes No
13. Overdose risk stratification:
    A. Do you have a history of overdose? ---------- Yes No
    B. Have a history of substance use disorder? --------- Yes No
    C. At risk of returning to a high dose of opioids? ----- Yes No
14. Are you taking any of the following?
    A. Opioid pain meds (ex. Norco, Percocet, Codeine, Vicodin, Methadone) Last dose? _____ Yes No
    B. Benzodiazepine (ex. Xanax, Valium, Ativan, etc) --- Yes No
    C. Antibiotics (ex. Amoxicillin, Z-Pak, Clindamycin)---- Yes No
    D. Anticoagulants/blood thinners (ex. Plavix, Coumadin, Pradaxa, Xeralto, Eliquis)---------- Yes No
    E. Blood pressure, Heart pills, Nitroglycerin---------- Yes No
    F. Cortisone (steroids)---------- Yes No
    G. Insulin, or Diabetes medication ---------- Yes No
    H. Diet pills, now or in the past, (ex. Fen-Phen Phentramine, Redux, Dexfenfluramine)---------- Yes No
15. Have you ever taken Bisphosphonate pills or injectables for osteoporosis or chemotherapy (ex. Fosamax, Actonel, Aredia, Boniva, Reclast, Zometa)? ---------- Yes No
    If yes, which form? (Please circle) Pills, injectable or both
    For how long? _____ Last dose? _____
16. Have you ever had radiation therapy to the head &/or neck? Why? When? _____ Yes No
17. Have you ever taken RANK ligand inhibitor or antiangiogenic medications (Prolia or Xgeva (denosumab) Sutent (sunitinib) Avastin (bevacizumab) Nexavar (sorafenib) Votrient (pazopanib) Afinitor (everolimus))? ---------- Yes No
18. Do you have TMJ (jaw joint) problems (pain, clicking, limited opening)? ---------- Yes No
19. Do you have dentures, loose crowns, temps? ---------- Yes No
20. Have you ever been told you need to take antibiotics before dental treatment/surgery? Why?_____ Yes No
21. Any adverse reactions or complications with prior anesthesia/sedation (family history)? Explain _____ Yes No
22. Are you pregnant? Are you nursing? ---------- Yes No
23. Are you **ALLERGIC** or have you reacted adversely to:
    A. Penicillin, Clindamycin, other antibiotics ----- Yes No
    B. Local Anesthetic (Lidocaine, Novocaine) ----- Yes No
    C. Pain pills (Norco, Percocet, Codeine, Vicodin) --- Yes No
    D. Barbiturates, sedatives, sleeping pills--------- Yes No
    E. Aspirin, NSAIDS (Motrin, Aleve, Ibuprofen)-- Yes No
    F. Egg, Soybean, Seafood, Shrimp, Iodine------- Yes No
    G. Latex---------- Yes No
    H. List all drug allergies _____
24. Have you had any of the following illnesses?

HEART (*circle condition*)
- High Blood Pressure, High Cholesterol---------- Yes No
- Chest Pain, Angina, Heart Attack---------- Yes No
- Heart Failure, Coronary Artery Disease---------- Yes No
- Heart Murmur, Irregular Heart Beat---------- Yes No
- Heart Surgery (Bypass, Stents, Valves, etc.)------- Yes No
- Stroke, TIA's, Fainting Spells---------- Yes No
- Rheumatic Fever, Heart Damage---------- Yes No
- Family History of Heart Disease---------- Yes No

LUNGS (*circle condition*)
- Asthma, Bronchitis---------- Yes No
- Emphysema, COPD---------- Yes No
- Lung Disease, TB, Chronic Coughing---------- Yes No
- Cough, Congestion or Fever in the past 4 weeks? Yes No

LIVER (*circle condition*)
- Hepatitis, Cirrhosis, Liver Disease/Cancer---------- Yes No

KIDNEY (*circle condition*)
- Kidney Disease, Dialysis---------- Yes No

GASTROINTESTINAL (*circle condition*)
- GERD, Stomach Ulcers---------- Yes No
- Gastrointestinal Disease/Cancer---------- Yes No

ENDOCRINE (*circle condition*)
- Diabetes – Insulin or Non-insulin Dependent------ Yes No
- Thyroid Disorders, Tumors or Cancer---------- Yes No

BLOOD (*circle condition*)
- Anemia, Hemophilia---------- Yes No
- Bleeding Disorders (any Family History)---------- Yes No

SKELETAL (*circle condition*)
- Arthritis, Osteoporosis---------- Yes No
- Artificial Joint Replacement---------- Yes No

OTHER (*circle condition*)
- Allergies, Sinus Troubles---------- Yes No
- Seizures, Epilepsy---Last episode _____--- Yes No
- Mental Disorders (Anxiety, Depression, ADD)----- Yes No
- Cancer of any type---Specify: _____--- Yes No
- Sleep Apnea, Heavy snoring ---------- Yes No
- Malignant Hyperthermia (any Family History) ---- Yes No
- HIV or AIDS---T-cell count_____------- Yes No
- Sexually Transmitted Diseases---Specify:_____ Yes No
- Autoimmune Disorders---Specify: _____--- Yes No
- Glaucoma---------- Yes No
- History of Organ Transplants---Specify:_____--- Yes No
- Eating Disorders (Anorexia, Bulimia, etc)---------- Yes No
- Other _____

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

Patient Signature: _____Date: _____

The doctor has reviewed the health history form above.

Doctor Signature: _____Date: _____