Four Corners Oral and Maxillofacial Surgery, PC

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Health Questionnaire

Name: _____ Social Security #: _____

Age: _____ Sex: _____ Weight: _____ Date of Birth: _____

Medical Doctor: _____ Referring Dentist: _____

Please answer all questions by circling yes (Y) or no (N) or no (N). Al All responses will be kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam: _____
4. Are you now under a physicians care for a particular problem? Y N
   If so, what for? _____
5. Have you had any serious illnesses, operations or hospitalizations? Y N
   If so, describe: _____
6. Have you had any adverse effects from dental treatment? Y N
7. Do you or have you ever had:
   A. Rheumatic fever or rheumatic heart disease? Y N
   B. Congenital heart disease? Y N
   C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)? Y N
   D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Y N
   E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder, or breakdown? Y N
   F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, do you bruise easily? Y N
   G. Liver disease (jaundice, hepatitis)? Y N
   H. Kidney disease? Y N
   I. Diabetes? Y N
   J. Thyroid disease (goiter)? Y N
   K. Arthritis? Y N
   L. Stomach ulcers or colitis? Y N
   M. Glaucoma? Y N
   N. Frequent or recurring mouth sores? Y N

O. Implants placed anywhere in your body (heart valve, knee, hip)? Y N

P. Radiation (x-ray) treatment for cancer? Y N

Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N

R. Sinus or nasal problems? Y N

S. Any disease, drugs, or transplant operation that has depressed your immune system? Y N

T. Recurrent infections of any kind? Y N

U. HIV or AIDS? Y N

8. Are you using or taking any of the following:

A. Tagamet? Y N

B. Thyroid medications? Y N

C. Antibiotics or sulfa drugs? Y N

D. Anticoagulants (blood thinners)? Y N

E. High blood pressure medicine? Y N

F. Steroids (Cortisone, etc.)? Y N

G. Tranquilizers? Y N

H. Insulin, diabenese, or similar drug? Y N

I. Digitalis, Inderal, Nitroglycerin, calcium channel blockers, Procardia or other heart medicine? Y N

J. Aspirin or ibuprofen (Motrin, Naprosyn, etc.)? Y N

How much daily? _____

K. Marijuana or other "street" drugs? Y N

L. Antihistamines or decongestants (seldane)? Y N

M. Are you taking any other regular medications, pills, or drugs? Y N

Please list all medications: _____

_____

_____

_____

9. Are you allergic or had a bad reaction to :

A. Local anesthetic (Novacaine, etc.)? Y N

B. Penicillin, Amoxicillin, Cephalosporins, or other antibiotics? Y N

C. Barbiturates, sedatives, etc? Y N

D. Aspirin or ibuprofen? Y N

E. Codeine or other pain killers? Y N

F. Latex or rubber products? Y N

G. Eggs? Y N

H. Other allergies or reactions? Y N

If yes please list:

10. Do you smoke or chew tobacco? ..... Y N
    How much? _____

11. Do you use alcohol? ..... Y N
    How much? _____

12. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? ..... Y N

13. Women : Are you pregnant or planning pregnancy? ..... Y N
    Last Menstrual Period _____
    Are you taking birth control pills? ..... Y N
    Are you taking hormone replacements? ..... Y N

14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? ..... Y N

15. Do you wish to talk with the doctor privately about anything? ..... Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

Signature of person completing health history Date: Dr.'s Initials