Four Corners Oral and Maxillofacial Surgery, PC

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Health Questionaire

Name:___________________________ Today's Date: _____________ Social Security #:____________________

Age: _____________ Sex:_________ Weight: ___________ Date of Birth:____________________

Medical Doctor: __________________________ Referring Dentist: ____________________________

Please answer all questions by circling yes (Y) or no (N) 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. "Strong" gag reflex? ____ Y N
   - P. Trouble swallowing pills? _____________________________________ Y N

- Q. Implants placed anywhere in your body (heart valve, knee, hip)? ________ Y N
- R. Radiation (x-ray) treatment for cancer? ________ Y N
- S. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ________ Y N
- T. Sinus or nasal problems? ________ Y N
- U. Any disease, drugs, or transplant operation that has depressed your immune system? ________ Y N
- V. Recurrent infections of any kind? ________ Y N
- W. 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
     What dose, and when was it last taken?
     ____
   - E. High blood pressure medicine? ________ Y N
     What dose, and when was it last taken?
     ____
   - F. Steroids (Cortisone, etc.)? ________ Y N
   - G. Tranquilizers, sedatives, barbiturates? ________ Y N
     What dose, and when was it last taken?
     ____
   - 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. Methadone or Suboxone? ________ Y N
   - L. "Street" drugs? ________ Y N
   - M. Antihistamines or decongestants (seldane)? ________ Y N
   - N. Are you taking any bone building medications?
     (Xgeva, Fosamax, Zometa, Arrydia, Prolia, Boniva, ect.)
     ________ Y N
   - O. Do you use an inhaler? ________ Y N
     How often? ________
     When was the last time you used your inhaler?
     ____
   - P. 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
What kind of reaction did you have?
____

C. Barbiturates, sedatives, etc? ______________________ Y N

D. Aspirin or ibuprofen? ______________________ Y N

E. Codeine, Oxycodone, Hydrocodone, or any other pain killers? ______ Y N
What kind of reaction did you have?
____

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 use marijuana? ______________________ Y N
What form? (Inhaled, edible, or other)______________________
How often? ______________

11. Do you smoke tobacco? ______________________ Y N
How much?______________

12. Do you use a vape pen? ______________________ Y N
How often? ______________

13. Do you chew tobacco? ______________________ Y N
How often? ______________

14. Do you use alcohol? ______________________ Y N
How much? ______________

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

16. 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

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

18. 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