

Oral Surgery Health Questionnaire

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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 Phentermine, 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: _____

Dr. Gonzalez has reviewed the health history form above.

Doctor Signature: _____ Date: _____