THE FACIAL SURGERY CENTER

ORAL-FACIAL & DENTAL IMPLANT SURGERY

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HEALTH QUESTIONNAIRE

Name _____ Date_____

Birthdate _____Age _____ Sex _____Height _____Weight _____Marital Status _____

Who is your general dentist? _____

Are you seeing any other dental specialist? _____

Who is your family physician? _____

Please list any surgeries or previous illnesses: _____

_____

_____

Have you had or currently have any of the following? If yes, please circle Y for YES or N for NO.

A. Stroke	Y / N	O. Arthritis	Y / N
B. Heart Murmur	Y / N	P. Stomach Ulcers	Y / N
C. Rheumatic Fever,	Y / N	Q. Kidney Trouble	Y / N
D. Rheumatic Heart Disease	Y / N	R. Tuberculosis	Y / N
E. High Blood Pressure	Y / N	S. Anemia	Y / N
F. Heart Attack	Y / N	T. Abnormal Bleeding	Y / N
G. Chest Pain	Y / N	U. Sexually Transmitted Infection	Y / N
H. Atrial Fibrillation	Y / N	V. Cancer	Y / N
I. Shortness of Breath	Y / N	W. AIDS	Y / N
J. Emphysema	Y / N	X. Tested HIV Positive	Y / N
K. Asthma	Y / N	Y. Porphyria	Y / N
L. Seizures	Y / N	Z. Thyroid Disease	Y/ N
M. Diabetes	Y / N		
N. Hepatitis, Jaundice, Liver Disease	Y / N		

Can you lay flat or in a significantly reclining position? Yes No

Are you taking any **blood thinner medication**? Yes No If you are taking medication, please list the type:

_____

Are you currently taking or previously taken **bisphosphonate medication** or any other drug for **osteoporosis**? Yes No If so please list the drug, duration, frequency, and any history associated with taking these drugs:

_____

Please list **all** medications, vitamins, and supplements: _____

_____

_____

_____

Do you have a **prosthetic joint**? Yes No Right knee, left knee, right hip, left hip, right shoulder, left shoulder, other: _____

Date of Surgery (Month and Year or Just Year): _____

Do you have **sleep apnea**? Yes No

Do you have an **internal pacemaker and/or defibrillator**? Yes No

Do you have a **prosthetic heart valve**? Yes No
Details as to what type of valve? _____
When was it inserted? _____

Do you have a **latex allergy**? Yes No Type of Reaction? _____

Are you **allergic to any medications**? Yes No
If so, please list the medication and the reaction that you had (anaphylaxis, rash, nausea, etc.): _____
_____

Have you or any other member of your family had a **bad reaction to any anesthetic**? Yes No
If yes, please explain: _____

Do you currently smoke **cigarettes or cigars**? Yes No Do you currently use **tobacco or snuff**? Yes No

Smoke (# packs/cigarettes per day) _____ How many years have you smoked? _____

Snuff Usage: How often do you use it? _____ How long have you used it? _____ yrs.

Have you previously quit smoking/use of tobacco? Yes No When did you quit and for how long? _____
Were you able to successfully kick the habit? Yes No

Do you drink **alcohol**? Yes No
If you do drink alcohol, what type of alcohol do you drink? Beer Wine Hard Liquor None
If so, how many drinks per week? _____

Do you use any **illicit drugs**? Yes No Please indicate type and frequency_____

Women: Are you pregnant? Yes No
If so, please give details such as what trimester, etc.: _____

Men: Are you taking any **erectile dysfunction medication**? Yes No
If so, please list the exact type and how often you are taking it: _____

Is there any other important information pertaining to *your* health history or general well-being so we can provide you with the best possible care? If so, please explain:

_____

_____

Patient's, Parent, or Guardian's Signature: _____

Reviewed by: _____Date:_____

(Assistant please date and initial when information is updated)

Updated:_____ Updated:_____

Updated:_____ Updated:_____

Updated:_____ Updated:_____