Prospect
Oral Surgery Center, LLC
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Monroe Township, NJ 08831

WEIGHT: _____
(WILL BE TAKEN IN OFFICE, DO NOT FILL IN)

HEIGHT: _____

HEALTH QUESTIONNAIRE (Confidential)

Today's Date • ___/___/_____ Patient's Name • _____ Birthdate • ___/___/_____

***PLEASE CIRCLE Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION.

1. Who is your family physician? _____ Phone number?_____
   When was your last checkup?_____ What was it for?_____
2. Have you had any:
   a. surgeries? Describe and give dates…… Y N
   _____
   _____
   _____
   b.. hospitalizations? Describe and give dates: _____
   _____
3. Have you ever had intravenous sedation or general anesthesia? …… Y N
   Were there any adverse effects?(Nausea, vomiting, drug reaction, delayed recovery)… …….. Y N
4. Do you generally tolerate dental treatment well? If no, why Not?_____. Y N
5. Have you ever had the following diseases?

   A. Heart disease that was detected at birth (congenital heart disease)?…….. Y N
   B. Rheumatic fever or Rheumatic heart disease? ……
   C. Cardiovascular disease (circle all that apply): chest pain, heart trouble, heart attack, Y N
   coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? ….If you have any heart surgery please explain and give dates:
   _____

   Are you taking any blood thinner as a result? Which blood thinner?_____ Y N
   *High Cholesterol/Triglycerides? (circle all that apply) Y N
   D. Lung Disease(circle all that apply): asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, severe cough? …… Y N
   E. Neurologic Disorders (circle all that apply): seizure, epilepsy, fainting, dizziness? ……Y N
   F. Emotional problems (circle all that apply): anxiety, depression, psychosis, schizophrenia,Y N
   bipolar, other mood disorder _____..
   G. Blood Disease (circle all that apply) :bleeding disorder, anemia, blood transfusion Y N
   What type of blood disease do you have?_____
   H. Liver Disease (circle all that apply) Jaundice, cirrhosis, hepatitis , liver transplant Y N

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I. Kidney Disease ? Y N
a. Are you on dialysis? Which days? _____ Y N
b. Have you had kidney transplant before? Y N
J. Diabetes? What type?____…… Y N
K. Thyroid Disease (hypothyroidism, hypethyrodism, tumor) ……..Y N
L. Arthritis? (which joints?) Y N
M. Stomach or Intestinal problems? (ulcer, acid reflux, hiatal hernia, colitis)…… Y N
N. Glaucoma? …… ……Y N
O. Implants/artificial joints anywhere in your body (Heart valve, hip, knee)?.. .. Y N
P. Radiation (X-Ray treatment for cancer) in head and neck region? …….…….…… Y N
Q. Chemotherapy for any reason? When?_____ Y N
R Any courses of steroid treatment currently or in the past two years? Y N
S Noises in jaw joint (TMJ), pain near ear when chewing, do you grind or clench teeth? ……. Y N
T. Sinus or nasal problems? … Y N

6. Please list any current medications (prescription and over-the-counter) AND any herbal supplements here:

_____

_____

_____

7. Are you allergic (Rash, hives, difficulty breathing) to any drugs and or food? Y N

Describe the reactions to individual drugs/food:

Drugs:_____

_____

Food:_____

8. Do you consume alcohol? How much and how often?_____ Y N

9. Do you or have you ever smoke cigarettes? One pack of cigarettes lasts how long? _____ Y N

Ex-smokers: When did you quit?_____, How much did you smoke before?_____ for how long?_____

Do you use spit tobacco? …For how long? _____ Y N

10. Do you or have you used any drugs before? Which ones?_____ Y N

11. Are you or have you been in any drug rehab programs before? Y N

12. Have you ever been on any bone density drugs called bisphosphonates (eg. Fosamax, Boniva,Actinel, etc.) for treatment for osteoporosis or bone cancer? Y N

13. (Female patients only):

A. Are you taking birth control pills? …… Y N
B. Are you pregnant, trying to become pregnant or any chance you might be pregnant? ……. Y N
C. Are you BREAST FEEDING?…… Y N
D. Are you taking hormonal replacement? …….. Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____ _____ [ ]

Patient's name Signature Date Doctor's initials

If someone other than the patient filled out the questionnaire please print your name and state your relationship with the patient: (Name, relationship to patient)

_____

Revised 1/14