rutner dental

Oral Surgery Health Questionnaire

Patient Name: _____ **Birth Date:** _____ **Chart Number:** _____

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you had food or drink today? Yes No
2. Are you in good health? Yes No
3. Your last physical examination was on _____
4. Are you now under the care of a physician? Yes No
   A. If so, what is the condition being treated?
   _____
5. Name and Telephone Number of Physician _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized? Yes No
   A. If yes, what was the problem and when? _____
   _____
7. Do you drink alcoholic beverages? Yes No
8. Please answer yes or no to all items below. Have you had any one of the following illnesses:

	Yes	No
Aids		
Allergies		
Anemia		
Angina		
Arthritis		
Artificial Joint Replacement		
Asthma		
Cancer		
Diabetes		
Emphysema		
Epilepsy		
Fainting		
Glaucoma		
Heart Attack		
Heart Bypass		
Heart Problem		
Hepatitis		
High Blood Pressure		
HIV Positive		
Kidney Disease		
Liver Problem		
Low Blood Pressure		
Lung Disease		
Rheumatic Fever		
Sinus Problem		
Stroke		
Thyroid		
Tuberculosis		
Venereal Disease		

Other _____
_____

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No
   A. Do you bruise easily? Yes No
   B. Have you ever required a blood transfusion? Yes No
   If "yes" explain circumstances _____
   _____
10. Do you have any blood disorder such as anemia? Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or lips? Yes No
12. Are you taking any drug or medicine? Yes No
    If yes, what medication _____
13. Are you taking any of the following?
    A. Antibiotics or sulfa drugs Yes No
    B. Anticoagulants (blood thinners) Yes No
    C. Medicine for high blood pressure Yes No
    D. Cortisone (steroids) Yes No
    E. Tranquilizers Yes No
    F. Aspirin Yes No
    G. Insulin, Tolbutamid Yes No
    H. Digitalis or drugs for heart problems Yes No
    I. Nitroglycerin Yes No
    J. Other _____
14. Are you allergic or have you reacted adversely to:
    A. Iodine Yes No
    B. Local anesthetic Yes No
    C. Penicillin or other antibiotics Yes No
    D. Sulfa drugs Yes No
    E. Barbiturates, sedatives, sleeping pills Yes No
    F. Aspirin Yes No
    G. Other _____
15. Have you had any adverse reaction associated with previous dental treatment? If so, explain: _____
    _____
16. Have you had any adverse reaction associated with previous medical problems? If so, explain: _____
    _____
17. Are you pregnant? Yes No

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware.

_____ _____
Patient Signature - or responsible party if patient is a minor — Date

I have reviewed the health history form above.

_____ _____
Doctor Signature — Date

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