North Denver Oral & Maxillofacial Surgery
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HEALTH QUESTIONNAIRE

Name: _____
Social Security No.:_____
Age:_____ Sex:_____ Height:_____ Weight: _____
Date of Birth: _____/_____/_____
Reason for today's visit:
_____
_____
_____

Please circle Yes or No and explain as necessary.

1. Are you in good health? . . . . . Yes No

2. Has there been any change in your health within the last year? . . . . . Yes No
If yes, please explain:
_____

3. Are you now under or have you ever been under the care of a physician? Yes No
If yes: Physician's name: _____
Reason:
_____
_____

4. Have you ever had any serious illness? . . . . . .Yes No
If yes, please list illness and date of diagnosis and treatment:
_____
_____
_____

5. Have you ever had surgery? . . . . . Yes No
If yes, please list the surgeries and dates:
_____
_____
_____

6. Have you ever been hospitalized? . . . . . Yes No
If yes, please explain and give dates:
_____
_____
_____

7. Do you have, or have you had ***heart, other cardiovascular problems, or chest pain***?

a) Heart murmur or heart valve defect . . . . . .Yes No

b) Heart valve replacement . . . . . Yes No

c) Rheumatic fever or rheumatic heart disease . . . . . Yes No

d) Congenital heart defect or problems . . . . . Yes No

e) Do you have a pacemaker . . . . . Yes No

f) Heart attack . . . . . Yes No

g) High blood pressure . . . . . .Yes No

h) Low blood pressure . . . . . .Yes No

i) Irregular or rapid heart beat . . . . . Yes No

j) Chest pain . . . . . .Yes No

k) Shortness of breath . . . . . .Yes No

l) CHF/ Congestive heart failure . . . . . .Yes No

m) Swollen ankles or hands . . . . . .Yes No

n) Artificial joints or prosthetics . . . . . .Yes No

o) Other heart, other cardiovascular problems, or chest pain? . . . . . Yes No
(please explain):_____

8. Do you have, or have you had ***lung problems***?

a) Asthma . . . . . .Yes No
b) Bronchitis, tuberculosis, or emphysema . . . . . Yes No
c) Other lung problems (please explain): . . . . . Yes No
_____

9. Do you have, or have you had the ***liver problems***?

a) Hepatitis or yellow jaundice . . . . . .Yes No
b) Other liver problems (please explain): . . . . . .Yes No
_____

10. Do you have, or have you had ***kidney problems***?

a) Frequent kidney infections . . . . . Yes No
b) Frequent urinary tract infections or burning during urination . . . . . .Yes No
c) Frequent urination, or blood in the urine . . . . . Yes No

d) Other kidney problems (please explain): . . . . . .Yes No
_____

11. Do you have, or have you had ***stomach or intestinal problems***?
a) Ulcers, blood in stool, black stools, or vomiting blood . . . . . Yes No
b) Other stomach or intestinal problems (please explain): . . . . . .Yes No
_____

12. Do you have, or have you had ***blood problems***?
a) Anemia . . . . . .Yes No
b) Bleeding problems . . . . . Yes No
c) Bruise easily . . . . . .Yes No

13. Do you have or have you had ***endocrine problems***?
a. Thyroid problems . . . . . Yes No
If yes, what type?
b. Cortisone or steroid treatments . . . . . .Yes No
c. Pheochromocytoma . . . . . Yes No
d. Diabetes . . . . . .Yes No
e. Hypoglycemia or low blood sugar. . . . . .Yes No

14. Stroke If yes, when: _____ . . . . . Yes No

15. Fainting spells, seizures, or epilepsy . . . . . .Yes No

16. Have you been diagnosed with glaucoma? . . . . . Yes No

17. Have you experienced tonsillitis? . . . . . Yes No

18. Sinus trouble, hay fever, hives, or skin rash . . . . . Yes No

19. Have you had, or do you have a serious viral illness? . . . . . Yes No

20. Arthritis or inflammatory rheumatism . . . . . Yes No

21. Gout . . . . . .Yes No

22. Persistent cough or coughing up blood . . . . . .Yes No

23. Sexually transmitted disease. . . . . Yes No
If yes, when_____

24. Do you have an autoimmune disorder . . . . . Yes No

25. Have you had abnormal bleeding . . . . . Yes No

26 Have you ever had any problem associated with tooth removal or other oral surgery?. . . . . Yes No
If yes, explain_____

27. Have you had any head, neck, or jaw injuries . . . . . .Yes No

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

29. Have you experienced any problems in your jaw, such as:
a. Clicking, popping, or grinding . . . . . .Yes No
b. Pain in the joint, ear, or side of face . . . . . Yes No
c. Difficulty opening or closing your mouth, or chewing . . . . . Yes No

30. List all surgeries and radiation treatment for a tumor/cancer:

_____

_____

31. Have you **ever** taken/been given Bisphosphonates (these drugs are used to treat osteoporosis and some cancers) including Aredia, Zometa, Boniva, Fosamax, Actonel, Reclast, alendronate, ibandronate, risedronate, pamidronate, or zoledronic acid? . . . . . Yes No

32. Please list any other diseases, illnesses, or health problems not covered above:

_____

_____

33. ***List all medications*** (and the dosages) and herbal substances that you are currently taking and have taken in the past 12 months:

_____

_____

34. Are you allergic to or have you had a bad reaction to any of the following:

Local anesthetics . . . . . Yes No
Penicillin or other antibiotics . . . . . Yes No
Aspirin . . . . . Yes No
Ketamine . . . . . Yes No
Iodine . . . . . .Yes No
Codeine or other narcotics . . . . . Yes No
Sulfa drugs . . . . . Yes No
Pain medication . . . . . Yes No
Steroids . . . . . .Yes No
Fentanyl . . . . . Yes No
Versed or Valium. . . . . .Yes No
Latex or rubber products. . . . . .Yes No

35. Do you have, or have you had any other ***allergies, including allergies to medicines or drugs***? . . . . . .Yes No
If yes, please explain:

_____

_____

36. Do you now or have you ever smoked? . . . . . .Yes No
If yes, do you smoke now? . . . . . .Yes No
If you quit smoking, when did you quit? _____
How many years have you or did you smoke? _____
How many packs per day do you or did you smoke on average?_____

37. Do you drink alcohol? . . . . . .Yes No
How much per day? _____
How many years? _____

38. Have you ever used illicit drugs? . . . . . Yes No
If yes, which ones? _____

39. Do you wear contact lenses? . . . . . Yes No

40. Do you wear removable dental appliances? . . . . . Yes No

41. ***Women:*** Are you pregnant, or is there any chance that you might you be pregnant? . . . . . Yes No

42. ***Women:*** Are you nursing? . . . . . .Yes No

I certify that I have read and understand the above. I will not hold my oral and maxillofacial surgeon, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient, Parent or Guardian *Date*

_____ _____
Signature of Doctor *Date*