Northpark Dental - Oral Surgery Health Questionnaire

Patient Name:____________________________________ Birthdate:____________________________

Age:_________ Sex:_________Height:_______ Weight:______ BMI:_______ BP:_________

PLEASE ANSWER ALL QUESTIONS AND FILL IN THE 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 and 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 medications, vitamins and supplements:_______________
   ____
9. Do you drink alcoholic beverages? 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 and/or any other legal or illegal synthetic and/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
       Anticoagulants / blood thinners (ex. Plavix, coumadin, Pradaxa, Xeralto, Eliquis)... Yes No
    d) Blood pressure, heart pills, Nitroglycerin...................... Yes No
    e) Cortisone (steroids).. Yes No
    f) Insulin, or Diabetes medication....................................... Yes No
    g) Diet Pills, now or in the past, (ex. Fen-phen Phentramine, 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 and/or neck?... Yes No
    Why? When?___________________________________
17. Have you ever taken RANK ligand inhibitor or Antiangiogenic medications (Prolia or Xgeva (denosumab) Sutent (sunitinib) Avastin (benacizumab) Nexavar (sorfenib) 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 or 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, Novocain)............................. 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).. Yes No
High Blood Pressure, High Cholesterol
Chest Paid, Angina, Heart Attack
Heart Failure, Coronary Artery Disease
Heart Murmur, Irregular Heartbeat
Heart Surgery (Bypass, Stents, Valves, etc.)
Stroke, TIA's, Fainting Spells
Rheumatic Fever, Heart Damage
Family History of Heart Disease

LUNGS (circle condition).. Yes No
Asthma, Bronchitis
Emphysema, COPD
Lung Disease, TB, Chronic Coughing
Cough, Congestion or Fever in the past 4 weeks?

LIVER (circle condition).. Yes No
Hepatitis, Cirrhosis, Liver Disease / Cancer

KIDNEY (circle condition).. Yes No
Kidney Disease, Dialysis

GASTROINTESTINAL (circle condition).. Yes No
GERD, Stomach Ulcers
Gastrointestinal Disease / Cancer

ENDOCRINE (circle condition)..Yes No
Diabetes – Insulin or Non-insulin Dependent
Thyroid Disorders, Tumors or Cancer

BLOOD (circle condition).. Yes No
Anemia, Hemophilia
Bleeding Disorders (any family history)

SKELETAL (circle condition).. Yes No
Arthritis, Osteoporosis
Artificial Joint Replacement

OTHER (circle condition).. Yes No
Allergies, Sinus Troubles
Seizures, Epilepsy --- Last Episode:________________
Mental Disorders (Anxiety, Depression, ADD)
Cancer of any type--- Specify:____________________
Sleep Apnea, Heavy Snoring
Malignant Hyperthermia (any family history)
HIV or SIDS ---- T -cell count:_____________________
Sexually Transmitted Diseases --- Specify:___________
Autoimmune Disorders---- Specify:_________________
Glaucoma
History of Organ Transplant---- Specify:_____________
Eating Disorders (Anorexia, Bulimia, etc.)
Other:_______________________________________

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

Dr. Carter has reviewed the health history form above.

Patient Signature:_______________________ Date:____________ Doctor Signature:___________________________ Date:____________