Oral and Implant Surgery of Northern Westchester, P.C.
HEALTH QUESTIONAIRE

Today's Date • ___/___/_____ Patient's Name • _____ Birthdate • ___/___/_____ Chart # (office use) #_____

_____
(Name of person completing form (if different from patient) and relationship to patient.)

***** PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION.**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last check-up by physician: ___/___/_____
4. Physician's Name: _____ Physician's Phone #: _____
5. Have you had any serious illnesses, operations, or hospitalizations? ..... Y N
   (Please describe, give approximate dates, doctor's name and phone #)
   _____
   _____
   _____
6. Have you ever had intravenous sedation or general anesthesia? ..... Y N
   Were there any adverse effects? ..... Y N
7. Do you generally tolerate dental treatment well? ..... Y N
8. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Heart Disease that was detected at birth? ..... Y N
   - B. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - C. Cardiovascular Disease (chest pain, heart attack, coronary artery disease, valve replacement, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? ..... Y N
   - D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? ..... Y N
   - E. Neurological Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? ..... Y N
   - F. Psychiatric Disorders (depression, ADD/ADHD, anxiety, bipolar, schizophrenia)? ..... Y N
   - G. Blood Disease (bleeding disorder, anemia, blood transfusion, bruise easily)? ..... Y N
   - H. Liver Disease (jaundice, hepatitis)? ..... Y N
   - I. Kidney Disease? ..... Y N
   - J. Diabetes? ..... Y N
   - K. Thyroid Disease (hypothyroidism, hyperthyroid)? ..... Y N
   - L. Arthritis? ..... Y N
   - M. Stomach ulcers, gastric reflux, colitis, IBS? ..... Y N
   - N. Glaucoma? ..... Y N
   - O. Frequent or recurring mouth sores? ..... Y N
   - P. Any artificial joint or osteoporosis? ..... Y N
   - Q. Radiation or chemotherapy for cancer? ..... Y N
   - R. Sinus or nasal problems? ..... Y N
   - S. Any disease, drug, or transplant operation that has depressed your immune system? ..... Y N
   - T. Recurrent infections of any kind? ..... Y N
9. ARE YOU TAKING ANY OF THE FOLLOWING (please list all medications on back of form):
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (blood thinners)? ..... Y N
   - C. Thyroid medications? ..... Y N
   - D. Antihistamines, decongestants? ..... Y N
   - E. High blood pressure or heart medication? ..... Y N
   - F. Steroids? ..... Y N
   - G. Tranquilizers, Antidepressants? ..... Y N
   - H. Stomach or GI medications (antacids, etc.)? ..... Y N
   - I. Cholesterol reducing drugs? ..... Y N
   - J. Aspirin, ibuprofen, NSAIDS, anti-inflammatory drugs, narcotics, or other pain relievers? ..... Y N
   - K. Have you ever taken Bisphosphonates (Fosamax, Actonel or other drugs for osteoporosis or Zometa, Aredia for multiple myeloma, breast or prostate cancer)? ..... Y N
   - L. Weight reduction pills or diet aids (prescription or over the counter)? ..... Y N
   - M. Vitamins, natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? ..... Y N
   - N. Marijuana, cocaine or other "recreational" drugs? ..... Y N

=> PLEASE LIST ALL CURRENT MEDICATIONS HERE => _____

_____
_____
_____
_____

10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:
    - A. Local anesthetic (Novocaine-like drugs)? ..... Y N
    - B. Penicillin, Amoxicillin, Cephalosporins? ..... Y N
    - C. Other antibiotics? ..... Y N
    - D. Barbiturates, sedatives? ..... Y N
    - E. Aspirin, ibuprofen, NSAIDS, or other pain medications? ..... Y N
    - F. Codeine or other narcotics or opioids? ..... Y N
    - G. Latex? ..... Y N
    - H. Other allergies or reactions? ..... Y N

    Please list: _____
    _____
11. Do you have hay fever, frequent skin rashes, etc.? ..... Y N
12. Do you use alcohol? ..... Y N
13. Do you smoke? ..... Y N

    How many per day? _____ For how long? _____
14. Do you use chewing tobacco? ..... Y N

    For how long? _____
15. Are you, or have you been, in a drug or alcohol recovery program? ..... Y N
16. Do you have any other disease, condition, or problem that you think the doctor should know about? ..... Y N
17. Do you wish to talk to the doctor privately about anything? ..... Y N
18. **WOMEN**
    - A. Are you taking birth control pills*? ..... Y N
    - B. Are you pregnant, trying to become pregnant or <u>any chance</u> you might be pregnant**? ..... Y N
    - C. Are you BREAST FEEDING? ..... Y N

    * Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Another form of birth control should be used for one complete menstrual cycle.

    ** If you are pregnant, surgery, anesthetics, and any medication may significantly harm your developing baby, especially during the first trimester.

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

_____ _____ ☐

Date Signature of person completing Health History Doctor's Initials

<u>THANK YOU</u>

To Be Completed By Patients Who Are Returning For Additional Treatment:

Medical Update: I have reviewed my health history above dated ____/____/_____ and confirm that it accurately states past and present conditions.

Exceptions: _____
_____
_____

Date: ____/____/_____ _____ ☐

Signature of person completing Health Update Doctor's Initials

Medical Notes:

_____ Pre-med needed Amox. Clinda. Zithro. Other: _____

_____ Steroid adjustment needed _____

_____ D/C med. _____ for _____ days. _____ PT/INR needed.

_____: Other special needs _____