HEALTH QUESTIONNAIRE

Patient Name: ______ Today's Date: ______

Date of Birth: ______ Sex: ◯ Male ◯ Female Height: ____ ft ____ in Weight: ____ lbs

Primary Physician: ______ Pharmacy: ______

What brings you here today - Chief Complaint? ______

Are you allergic to: **(Check ALL that applies)**

☐ Latex ☐ Penicillin ☐ Tylenol ☐ Novocaine ☐ Codeine ☐ Eggs

Other: ______

Are you taking: **(Check ALL that apply)**

☐ Coumadin ☐ Warfarin ☐ Plavix ☐ Aspirin ☐ Osteoporosis Meds (Reclast, Boniva)

Please **LIST ALL** other medicine(s) including non-prescription you are taking (i.e. Aspirin, ibuprofen, pain killers, etc.) and/or herbal remedies (i.e. St. John's Wort, SAMe, ephedra, gingko biloba, ginseng, androstenedione) ?

Other Meds: ______

Have you had any of the following? **(Check ALL that apply)**

☐ High Blood Pressure	☐ Emphysema	☐ Dialysis	☐ Radiation Therapy
☐ Heart Attack/MI	☐ Tuberculosis	☐ Kidney Disease	☐ Treatment of Cancer
☐ Chest Pain	☐ Asthma	☐ Diabetes	☐ Psychiatric Treatment
☐ Heart Surgery	☐ Lung Problems	☐ Thryoid Disease	☐ Artificial Joints
☐ Heart Trouble	☐ Jaundice	☐ Anemia	☐ Arthritis
☐ Heart Murmur	☐ Hepatitis A/B/C/D	☐ Transfusion	☐ Estrogen/Steroid Meds
☐ Mitral Valve Prolapse	☐ Excessive Bleeding	☐ Seizure Disorder	☐ HIV/AIDS
☐ Rheumatic Fever	☐ Liver Disease	☐ Stroke	☐ Sinusitis
☐ Shortness of Breath	☐ Kidney Failure	☐ Ulcers/Gastric Reflux	☐ Glaucoma

Others? ______

◯ Yes ◯ No Are you required to take predmedication (antibiotic) prior to any dental or surgical procedures?
Please Explain: ______

◯ Yes ◯ No Have you or any member of your family had trouble with general anesthesia? Who? ______

◯ Yes ◯ No Are you on birth control?

◯ Yes ◯ No Are you aware ANTIBIOTICS can make your birth control medication ineffective?

◯ Yes ◯ No Is there a chance you could be pregnant?

◯ Yes ◯ No If you recently had a child, are you still nursing?

◯ Yes ◯ No Do you smoke? ____ packs/day? ____ Number of yrs? Quit ____ yrs ago?

◯ Yes ◯ No Do you drink alcohol? How often? ____ oz per ◯ Day ◯ Month ◯ Year

◯ Yes ◯ No Do you use recreational drugs?

Are there any other medical problems or concerns that you would like to share? ______

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, 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/Guardian: ______________________ Date: ______

Signature of Doctor: ______________________ Date: ______

Maine Oral & Maxillofacial Surgery Associates, P.A.