Waterman
Oral and Maxillofacial Surgery

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HEALTH QUESTIONNAIRE

Please circle either Y (yes) or N (no) of the following: Name: _____

Y N Anemia	Y N Hay Fever	Y N Heart Trouble
Y N Bleeding Disorder	Y N Sinus Problems	Y N Heart Attack, What Year____
Y N HIV/AIDS	Y N Tuberculosis	Y N Heart Murmur
Y N Hepatitis Type ____	Y N Tobacco/Smoking	Y N Mitral Valve Prolapse
Y N Liver Disease	Y N Lung Disease	Y N Chest Pain or Angina
Y N Alcohol Usage	Y N Colon Disease	Y N Pacemaker/Artificial Valves
Y N Drug Usage	Y N Stomach Problems/Ulcers	Y N Frequent Swollen Ankles
Y N Cancer Type ____	Y N Frequent Headaches	Y N Arthritis
Y N Chemotherapy	Y N Psychiatric Care	Y N Cortisone Treatment
Y N Radiation Therapy	Y N Nervous Disorder	Y N Artificial Joints
Y N Head/Neck Radiation	Y N Epilepsy/Seizures	Y N Osteoporosis
Y N Diabetes	Y N Fainting	Y N Thyroid Problems
Y N Kidney Disease	Y N Glaucoma	Y N Jaw Pain/TMJ
Y N Asthma	Y N Low Blood Pressure	Y N Recent Cough or Cold
Y N Bronchitis	Y N High Blood Pressure	Y N Unexplained Weight Loss
Y N Emphysema	Y N Stroke, What Year _____	Y N Venereal Disease
YN Obstructive Sleep Apnea	Y N Other_____	

ALLERGY OR SENSITIVITY TO ANY OF THE FOLLOWING:

___Penicillin	___Aspirin	___Latex Gloves	___Barbiturates/Sleeping Pills
___Codeine	___Iodine	___Sulfa/Sulfur Drugs	___Novocaine/Local Anesthetics
___Peanuts	___Soy		

Any additional allergies of medications not listed: _____

Have you ever used Fosomax, Zometa, Aredia, Boniva, Actonel, Skelid, Reclast, Didronel or any other type of Bisphosphonate? _____ If yes, when and for how long? _____

Please circle any of the following if you are currently on or have recently taken: Coumadin, Aspirin, Ibuprofen, Advil, Motrin or Aleve. Please indicate the last time you took this medication: _____

Have you been hospitalized within the past 5 years? _____ If yes, Please explain _____

_____

Have you been under the care of a physician during the past 2 years? _____ If yes, Please explain_____

_____

Have you been taking medication within the past 2 years? _____ If yes, please list meds

_____

Have you ever had general anesthesia for an operation? _____ If yes, please explain _____

_____

Have you or a family member ever had an unfavorable reaction to a general anesthetic? _____

_____

WOMEN:

Are you pregnant? Y N Are you nursing? Y N Are you taking birth control pills? Y N

SIGNATURE:_____ DATE:_____

(parent or legal guardian to sign if under 18)

Dr.'s initials _____ Date _____ Time _____