Health Care Questionnaire: CONFIDENTIAL **West Coast Oral Surgery**

Patient's Name:_____ Age:_____ Date:_____

Please indicate YES or NO if you have or had any of the following:

YES	NO		YES	NO		YES	NO	
O	O	Recent illness (within 1 year)	O	O	Irregular heartbeat/palpitations	O	O	Thyroid disease
O	O	Cough, cold or flu (recent)	O	O	Heart murmur	O	O	Seizures or epilepsy
O	O	Nasal obstruction	O	O	Rheumatic fever	O	O	Psychiatric treatment
O	O	Loud Snoring	O	O	Scarlet fever	O	O	Liver disease / cirrhosis
O	O	Difficulty opening mouth / TMJ	O	O	High blood pressure	O	O	Alcoholism / drug abuse
O	O	Lung disease	O	O	Blood vessel grafts	O	O	Jaundice
O	O	Shortness of breath	O	O	Heart surgery	O	O	Hepatitis
O	O	Asthma	O	O	Stroke	O	O	Stomach ulcer
O	O	Bronchitis	O	O	Arthritis	O	O	Diabetes
O	O	Emphysema	O	O	Artificial joints	O	O	Kidney Disease
O	O	Tuberculosis (TB)	O	O	Cortisone or steroid use	O	O	HIV+ / AIDS
O	O	Heart failure	O	O	Extensive bleeding	O	O	Osteoporosis
O	O	Chest pain	O	O	Anemia	O	O	Other_____
O	O	Heart attack	O	O	Treatment for tumor or cancer/radiation			_____

Antibiotic and pain medications can alter the effectiveness of birth control pills. Use another method of birth control for the remainder of the menstrual cycle while taking antibiotics or pain medications. (If this applies to you, please initial:_____)

YES	NO	
O	O	Are you in good health?
O	O	Are you having pain or discomfort at this time?
O	O	Have you had a bad experience with previous dental or surgical treatment?
O	O	Have you been under the care of a physician or hospitalized during the past two years? If yes for what? _____
O	O	Have you ever gone to sleep (deep sedation or general anesthesia) for an operation? If yes for what? _____
O	O	Have you had any complications from anesthesia or previous surgery? If yes describe: _____
O	O	Have any family members had a serious reaction to a general anesthetic?
O	O	Are you taking any medications? Please list (include over the counter medications, products with aspirin or ibuprofen, vitamins, birth control pills, CBD/THC products):_____
O	O	Have you ever taken weight loss medication or any herbal or homeopathic supplements (e.g. vitamin E or fish oil)? _____
O	O	Have you or do you currently take any medications for osteoporosis or bone cancer such as Fosamax, Boniva, Actonel, Reclast, Aredia, Zometa, Didronel or Skelid? _____
O	O	Have you used recreational drugs during the last year? Please list as they can be dangerous in conjunction with anesthetic drugs:_____
O	O	Do you smoke or chew tobacco? If yes, how long?_____ If you smoke, how many packs a day?_____
O	O	Have you vaped?How often _____ last date of use _____ type: (circle all apply) tobacco marijuana/THC CBD
O	O	Are you pregnant? If yes, how many months?_____
O	O	Do you drink alcoholic bevarages? If so, how many drinks do you consume per week? _____
O	O	Do you wear dentures or partials?
O	O	Do you wear contact lenses?
O	O	Do you have trouble swallowing pills?

Please indicate if you have allergies of any type, including allergies to soy or soy products, milk or milk products, or latex:

YES	NO		YES	NO	
O	O	Penicillin / ampicillin / amoxicillin	O	O	Aspirin
O	O	Novocain - local anesthetics - epinephrine	O	O	Barbiturates
O	O	Codeine	O	O	Other drugs/medications/foods/materials:_____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health status, or if my medications change, I will inform the doctor accordingly.

Patient's or legal guardian's signature:_____ **Date:**_____

If patient is a minor, please indicate relationship to patient:_____

For Office Use Only

Date:_____BP:_____ Pulse:_____ Resp:_____ Weight:_____ Ht:_____ ASA:_____ Reviewed by:_____

Date:_____BP:_____ Pulse:_____ Resp:_____ Weight:_____ Ht:_____ ASA:_____ Reviewed by:_____