HEALTH QUESTIONNAIRE

R. JONAS **COLLINS**, DMD
Oral Surgery | Dental Implant Center

Name: _____ Social Security #: _____

Age:_____Sex:_____ Height:_____ Weight:_____Date of Birth: _____/_____/_____

Please circle Yes or No

Yes No Has there been any change in your health within the last year? IF yes, please explain_____

_____

Yes No Do you see your physician regularly?

Yes No Have you had any serious illness or operations?

Yes No Have you been hospitalized in the past 5 years? IF yes, please explain_____

_____

Do you have, or have you had any of the following?

Yes No Rheumatic fever or rheumatic heart disease

Yes No Congenital heart defect or problems

Yes No Other heart problems or heart attack (When?_____)

Yes No Any valve replacement (Which valve?_____)

Yes No High blood pressure

Your average blood pressure is: _____

Yes No Irregular or rapid heart beat

Yes No Atrial Fibrillation

Yes No Are you taking any blood thinners?

For what condition? _____

IF yes, what do you take?_____

Yes No Chest pains

Yes No Shortness of breath

Yes No Swollen ankles

Yes No Asthma

What triggers your asthma?_____

Yes No Do you use an inhaler?_____ Last Used: _____

Yes No Have you been hospitalized for you asthma?

Yes No Can you climb a flight of stairs without getting winded?

Yes No Bronchitis, tuberculosis, or emphysema

IF yes, please explain _____

Yes No Hepatitis or yellow jaundice

Yes No Frequent kidney infections

Yes No Frequent urinary tract infections or burning during urination

Yes No Frequent urination, or blood in the urine

Yes No Anemia

Yes No Bleeding problems

Yes No Bruise easily

Yes No Ulcers, blood in stool, black stools, or vomiting blood

Yes No Sinus trouble, hay fever, hives or skin rash

IF yes, what caused your symptoms _____

_____

Yes No Fainting spells, seizures, or epilepsy

Yes No Hypoglycemia or low blood sugar

IF yes, how do you control your symptoms_____

_____ Last A1C level:_____

Yes No Diabetes or high blood sugar

IF yes, when did you last check your blood sugar? _____

_____ Your level was:_____

Yes No Arthritis or inflammatory rheumatism

Yes No Persistent cough or cough up blood

Yes No Stroke

IF yes, when:_____ What type of stroke?_____

Yes No Sexually transmitted disease

IF yes, when were you treated: _____

Yes No Do you have an auto-immune disadvantage or disorder

Yes No Have you had abnormal bleeding or any problem associated with previous tooth removal or oral surgery

Yes No Do you smoke

For how long?_____ How many per day?_____

Yes No Do you consume alcoholic beverages?

Yes No WOMEN: Are you or might you be pregnant?

Please list any other diseases, illnesses, or health problems not covered above:_____

_____

_____

List all medications that you are currently taking and why you are taking them (use back of this page if necessary): _____

_____

_____

List all surgeries, x-ray or radiation treatment for a tumor, growth, or other condition in the past 10 years:_____

_____

Do you have, or have you had allergy problems, including allergies to medicines or drugs? Please explain: _____

_____

_____

Signature of Patient/Parent/Guardian: _____ Date:_____

Signature of Doctor: _____ Date:_____