ONCE COMPLETED PLEASE EMAIL FORM TO: clemensoralsurgery@gmail.com

HEALTH QUESTIONNAIRE FOR DR. STEPHEN CLEMENS, DMD

Patient Name: ______________________________________ **Today's Date**: _____________________

Patient Age: _______ **Male**: ___**Female**: ___**Height**: _______ **Weight**: _____**Are you wearing eye contacts?** Y___ N____ ___

Although as oral surgeons we primarily treat the area in and around your mouth, we need to review your overall general health. Any Medical problems that you may have, or medications prescribed by other providers, can significantly affect the care we provide. We are required by law to maintain the privacy of your health information and we will use it only in your treatment unless you authorize otherwise.

	PLEASE ANSWER THE FOLLOWING QUESITONS "Yes" or "No"	**YES**	**NO**
1.	Are you required to take antibiotic pre-medication prior to dental procedures?		
2.	Do you have any allergies to medications? **Please List:**		
3.	Are you allergic to eggs, soy or any other food allergies?		
4.	Do you have an artificial joint or implant in your hips, knees, shoulders, etc.?		
5.	Have you ever had complications from general anesthesia or dental treatment?		
6.	Are you currently taking any medications prescribed by a doctor? (****please List Below***)		
7.	Do you have inflamed areas, growths or sore spots in or around your mouth?		
8.	Do you have any unhealed injuries?		
9.	Are you being treated by a physician for any chronic medical problems?		
10.	Have you ever been hospitalized?		
11.	Do you have a cold or sore throat now?		
12.	Do you have clicking, popping, or pain in your jaw joints?		
13.	Do you have frequent or severe headaches?		
14.	Do you have any vision impairment or hearing loss?		
15.	Has a physician told you that you have a heart murmur or heart disease?		
16.	Have you had a heart attack?		
17.	Have you had a heart valve repair or replacement?		
18.	Are your ankles often swollen?		
19.	Do you get short of breath, even without exertion? a. Asthma? b. Sleep Apnea?		
20.	Do you currently have a cough or chest congestion?		
21.	Do you smoke or use tobacco/ Cannabis Quantity: Frequency:		
22.	Do you have stomach or bowel problems?		
23.	Do any medications make you nauseated?		
24.	Has a physician told you that you have kidney disease?		
25.	Are you frequently thirsty?		
26.	Do you have a bleeding disorder or blood disease?		
27.	Have you ever had severe bleeding after dental extractions or cuts?		
28.	Do you take blood thinning medication such as ***Coumadin***?		
29.	Have you ever fainted?		
30.	Have you ever had a seizure? Date of last seizure:		
31.	Are you taking anti-seizure medications?		
32.	Have you ever had radiation therapy or chemotherapy?		
33.	Are you taking osteoporosis medications such as ***Fosamax***, ***Boniva***, or ***Aredia***?		
34.	Are you nursing?		
35.	Is there a possibility you are pregnant? Estimated due date:		
36.	Are you taking birth control pills, Depo Provera or using a patch?		
37.	Do you take any medications for anxiety or sleeplessness?		

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH:

___ Anemia
___ Arthritis
___ Asthma
___ Cancer
___ Diabetes
___ Emphysema
___ Glaucoma
___ Hepatitis or Jaundice
___ High Blood Pressure
___ HIV or AIDS
___ Immunosuppressive Conditions
___ Latex Allergy
___ Pneumonia
___ Pulmonary Disease
___ Rheumatic Fever
___ Thyroid Condition
___ Tuberculosis
___ Other: _______________

___ None of the Above

Staff Use Only:

BP: _______________

P: _______________

R: _______________

T: _______________

IMPORTANT INFORMATION: Medications used in routine oral surgery may interact with street/illicit drugs as well as prescription medications. These interactions can be severe and ***may be life-threatening***. It is extremely important that you inform your surgeon on any drug that you are using currently, or may have taken recently, so it can be taken into consideration in planning your oral surgery. We will keep this information in the strictest confidence, using it only to ensure your safe and appropriate surgical care.

****Please List any Medications you are currently taking here:***