Center For Corrective Surgery
Mansoor Madani, D.M.D.

Confidential Health Questionnaire

Some general information concerning your medical and dental history is essential for proper surgical diagnosis, treatment and record maintenance. Please fill out the following to the best of your knowledge. If you have any questions, we will be happy to assist you. Please note that the procedures recommended will not cure your entire medical or dental problems and additional treatments may be necessary.

Name ____

Primary Dentist's Name and Address ____

Primary Doctor's Name and Address ____

My major problem or reason for seeking treatment is:

- ❒ Snoring
- ❒ Sleep Apnea*
- ❒ Chin Surgery
- ❒ Jaw Surgery
- ❒ Post-Nasal Drip
- ❒ Nasal Polyps
- ❒ Chronic Nasal Congestion
- ❒ Chronic Sinusitis
- ❒ Home Sleep Study
- ❒ Chronic Tonsillitis
- ❒ Other ______________________________

1. Have you ever had a serious illness or major operation? ❒ YES ❒ NO
   If yes, please describe: ____
2. Have you ever had General Anesthesia? ❒ YES ❒ NO
   If yes, please describe: ____
3. Are you now under the care of a physician? ❒ YES ❒ NO
   If yes, what is the condition being treated? ____
4. Are you presently taking any medications or drugs? ❒ YES ❒ NO
   If yes, please list them: ____
5. Are you presently taking any of the following medication?
   ❒ Aspirin ❒ Vitamin E ❒ Coumadin (blood thinner) ❒ Herbal Supplements
6. Have you ever had an allergic reaction to medication or anesthesia? ❒ YES ❒ NO
   If yes, please describe: ____
7. Have you ever required a blood transfusion? ❒ YES ❒ NO
8. Have you ever been in contact with any individual having Hepatitis, Tuberculosis (T.B.) or AIDS? ❒ YES ❒ NO
9. Are you addicted to or recovering from any drug or alcohol addiction? ❒ YES ❒ NO
10. Are you wearing contact lenses? ❒ YES ❒ NO
11. Do you have any visual or hearing problems, or any other disabilities, which we should consider in planning your oral surgical treatment? ❒ YES ❒ NO
    If yes, please describe: ____

*** Please note that the laser surgery or other procedures recommended and performed here <u>will not cure sleep apnea</u>.**

Pharmacy Name ______________________________ **Phone** ____________________
Street ______________________________ **City** ____________________ **State** ______

over please

12. Have you ever taken/used or currently take/use any of the following?

❐ Appetite Suppressant (such as Fen-Phen) ❐ Tobacco ❐ Alcohol ❐ Recreational Drugs

For Women Only: a. Are you pregnant or trying to become pregnant? ❐YES ❐NO

b. Are you taking birth control pills or hormones? ❐YES ❐NO

(Please note any medications prescribed, for your surgical care may interfere with the action of birth control pills.)

13. Do you have a history of any of the following? (Please check yes or no)

	Yes	No		Yes	No
High blood pressure / Hypertension			Anemia		
Heart murmur			Bleeding disorder		
Rheumatic fever / Rheumatic Heart Disease			Kidney disease		
Mitral valve prolapse			Dialysis		
Angina pectoris / Chest pain upon exertion			Organ transplant		
Heart or bypass surgery			Cancer		
Heart Disease			Radiation therapy		
Prosthetic (artificial) heart valve			Chemotherapy		
Irregular / Rapid heart beat			Epilepsy / Seizure / Convulsion		
Pacemaker / Implanted defibrillator			Stomach ulcer / Hyper-acidity		
Heart attack			Colitis / Intestinal problem		
Stroke / TIA			Arthritis and/or painful swollen joints		
Sleep Apnea			Prosthetic (Artificial) joints		
Emphysema / Respiratory problems			Jaw joint pain (TMJ) or clicking/popping		
Asthma or Hay fever			Sexually transmitted disease		
Diabetes			AIDS / HIV		
Hypoglycemia			Tuberculosis (TB)		
Thyroid disease			Frequent or recurring mouth sores		
Persistent swollen neck glands			Hepatitis / Jaundice / Liver Disease		
Psychiatric treatment			Allergy to latex		

If you answered “Yes” to any of the above questions, please explain below and if there is any other significant information concerning your past medical or dental history, please describe and discuss it with your doctor:

____

____

14. Do you have any other medical problems not listed above? ____________________________

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Consent and Permission is hereby granted to the staff of this office for such procedures and anesthesia as may be necessary for the care of the undersigned patient. Permission is granted to release my medical-surgical records to my primary Dentist or Physician. 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 responsible for any errors or omissions that I may have made in the completion of this form.

Patient’s Signature ______________________________________ **Date** ____________

Legally responsible person if patient cannot sign or is a minor (under 18) ____________________

Relationship of the above to the patient ______________________________________

Doctor’s Comments: ____

____

Doctor’s Signature ______________________________________ **Date** ____________

Thank you!