

Bala Institute of Oral Surgery

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Confidential Health Questionnaire

Some general information concerning your medical and dental history is essential for proper oral 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.

Name _____ Date of Birth ____/____/____
 Emergency Contact _____ Phone (____) _____
 General Dentist _____ Phone (____) _____

My major problem or reason for seeking treatment is:

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Extractions | <input type="checkbox"/> Dental Implants |
| <input type="checkbox"/> Fractured Jaw | <input type="checkbox"/> Jaw Surgery | <input type="checkbox"/> Oral Lesions | <input type="checkbox"/> Cysts or Tumors |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Apicoectomy | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> 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? If yes, what is the condition being treated? YES NO

4. Do you currently have a persistent cough? If yes, duration: _____ YES NO
- 5a. Are you presently taking any medications or drugs? YES NO
 If yes, please list them: _____
- 5b. Are you presently taking any of the following medication?
 Aspirin Vitamin E Coumadin (blood thinner) Herbal Supplements
 Fosomax Bisphosphonatesm Didronel Aredia Actonel Zometa Boniva
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: _____

Pharmacy Name _____ Phone _____ Street _____ City _____ State _____

over please

12. Do you have a history of any of the following? (Please check yes or no - do not leave blank)

	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		
Osteoporosis			Bone cancer		
Bone disease			Paget's disease		
Osteogenesis imperfecta			Myeloma / Multiple Myeloma		

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:

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

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

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

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 oral surgical care may interfere with the action of birth control pills.)

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!