SOUTH CALGARY ORAL & MAXILLOFACIAL SURGERY
Confidential Health Questionnaire

Name: ______________________ **DOB:** ____/____/____ **Date:**______________
M D Y

Are you experiencing any pain at this time? .... Yes ☐ No ☐
Do you clench or grind your teeth? .... Yes ☐ No ☐
Have you had any problems with local anaesthetic (freezing)? .... Yes ☐ No ☐
Do you have any allergies or unusual reactions to any medications or foods? .... Yes ☐ No ☐

....

Please list all medications/pills/herbal medicines you are taking or have been taking **including their frequency & dosage.**

....

....

Please list any disabilities ....

For women using oral contraceptives, if taking oral antibiotics you will need another form of birth control for one complete cycle.

Have you had any previous serious illnesses? (please list) .... Yes ☐ No ☐

....

Have you ever had a general anesthetic or previous surgeries (please list below)? .... Yes ☐ No ☐

....

Have you or any member of your family ever had a bad reaction to general anesthetic? .... Yes ☐ No ☐
Do you have high blood pressure? .... Yes ☐ No ☐
Have you ever had rheumatic fever or scarlet fever? .... Yes ☐ No ☐
Do you have a heart murmur? .... Yes ☐ No ☐
Do you have any heart problems .... Yes ☐ No ☐
Do you have any liver disease? .... Yes ☐ No ☐
Do you have any kidney disease? .... Yes ☐ No ☐
Do you have diabetes? .... Yes ☐ No ☐
Do you have any breathing or lung problems (bronchitis, etc.)? .... Yes ☐ No ☐
Do you have any asthma? .... Yes ☐ No ☐
If yes, medications ....
Last attack .... Hospitalization ....
Do you have any implants in your body (heart valve, knee, hip)? .... Yes ☐ No ☐
Have you had radiation treatment for cancer? .... Yes ☐ No ☐
Do you suffer from osteoporosis? .... Yes ☐ No ☐
Are you on bisphosphates? (i.e. fosamax, didrocal, actonel) .... Yes ☐ No ☐
Do you suffer from reflux or other gastrointestinal disease? .... Yes ☐ No ☐
Do you have a history of glaucoma? .... Yes ☐ No ☐
Have you ever been tested for A.I.D.S./HIV? When .... Results .... Yes ☐ No ☐
Have you ever been tested for Hepatitis A, B, or C? When .... Results .... Yes ☐ No ☐
Have you had a bleeding problem or blood disorder? .... Yes ☐ No ☐
Are you taking blood thinners (anticoagulants)? .... Yes ☐ No ☐
Have you ever had a seizure? .... Yes ☐ No ☐
Do you think you might be pregnant/Are you nursing? .... Yes ☐ No ☐
Do you smoke? If so, how much? .... Yes ☐ No ☐
Do you use any street drugs? .... Yes ☐ No ☐
Are you suffering from any psychological or mental disorders and/or handicaps? .... Yes ☐ No ☐
Do you drink alcohol? .... Yes ☐ No ☐
If so, what is your average intake per week? Number of Alcoholic Beverages ....
Do you suffer from sleep apnea? .... Yes ☐ No ☐

Height ______________ Weight______________

To the best of my knowledge, the above information is correct. ______________________
Patient's Signature/Legal Guardian