

Sarasota Oral & Implant Surgery



ORAL MAXILLOFACIAL SURGERY | DENTAL IMPLANTS | BOARD CERTIFIED

2130 South Tamiami Trail | Sarasota FL 34239

Phone 941-365-3388 | Fax 941-954-0521

Confidential Health Questionnaire

Prescribed current medications? Yes No Please List: _____

Are you allergic to any medications? Yes No Please List: _____

Do you have or have you ever had (please check):

- | | | |
|---|--|--|
| <input type="checkbox"/> Ankle Swelling / Heart Failure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Malignancy / Cancer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Neurologic Disease |
| <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Dementia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Pacemaker / Defibrillator | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Alcohol or Drug Abuse | <input type="checkbox"/> Gastritis / Colitis / IBS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Anemia / Abnormal Bleeding | <input type="checkbox"/> Hearing Impaired | |
| <input type="checkbox"/> Angina or Chest Pain | <input type="checkbox"/> Hepatitis / Liver Disease | |

Do you use tobacco products in any form? Yes No Do you use any alcohol products? Yes No

Have you been hospitalized in the past year? Yes No If so, why? _____

Have you ever had radiation therapy to the head or neck? Yes No Comment: _____

Have you ever taken bisphosphonate drugs (drugs that strengthen your bones)? Yes No Name: _____

Past Surgeries? Yes No : _____ Complications? Yes No : _____

Female Patients Only

Are you pregnant or nursing? Yes No

(If unsure, please check with your physician prior to any surgical procedure.)

Do you use oral contraceptives? Yes No

Certain antibiotics prescribed in this office may interfere with the effectiveness of oral contraceptives. It is recommended that you use an additional method of birth control if antibiotics are prescribed. However, continue the use of your birth control as prescribed.

I have read, understood, and attest that the medical history I have given is full and correct.

Print Name: _____ Date: _____

Patient Signature: _____