East Valley Oral Surgery, P.C.
Eric Engel, D.D.S., M.D.
3800 West Ray Road ~ Suite 14 ~ Chandler AZ 85226
Office: (480)812-8200 Fax: (480) 812-8522

Health Questionnaire

Name:___________________________Social Security#:___________________________

Age:_________Sex:_________Height:______________Weight:_______Date of Birth:________________

Please Circle Yes or No.

1. Has there been any change in your health within the last year?. . . . . .Yes No
   If yes please explain:____
2. Are you now under the care of a physician? . . . . Yes No
3. Have you ever had or serious illness or operation? . . . . Yes No
4. Have you been hospitalized in the past five years? . . . . Yes No
   If yes please explain:____
5. Do you have, or have you ever had ***heart problems***?
   a. Heart Murmur or heart valve defect . . . . .Yes No
   b. Rheumatic fever of rheumatic heart disease . . . . Yes No
   c. Heart valve replacement . . . . .Yes No
   d. Congenital heart defect or problems . . . . Yes No
   e. Do you have a pacemaker. . . . . .Yes No
   f. Heart problems or heart attack . . . . Yes No
   g. High blood pressure. . . . . Yes No
   h. Low blood pressure. . . . . Yes No
   i. Irregular or rapid heart beat. . . . . .Yes No
   j. Chest pains. . . . . Yes No
   k. Shortness of breath. . . . . Yes No
   l. Swollen ankles or hands. . . . . Yes No
   m. Artificial joints or prosthetics. . . . . Yes No
6. Do you have, or have you ever had ***lung problems***?
   a. Asthma . . . . .Yes No
   b. Bronchitis, Tuberculosis, or emphysema. . . . . Yes No
   c. Other lung problems:____
7. Do you have, or have you ever had ***liver problems***?
   a. Hepatitis or yellow jaundice. . . . . Yes No
   b. Other liver problems:____
8. Do you have, or have you ever had ***kidney problems***?
   a. Frequent kidney infections. . . . . Yes No
   b. Frequent urinary tract infections or burning during urination. . . . . Yes No
   c. Frequent urination or blood in the urine. . . . . Yes No
   d. Other kidney problems:____
9. Do you have, or have you ever had ***blood problems***?
   a. Anemia. . . . . Yes No
   b. Bleeding problems. . . . . Yes No
   c. Bruise easily. . . . . Yes No
10. Do you have, or have you ever had ***stomach or intestinal problems***?
    a. Ulcers, blood in stool, black stools or vomiting blood. . . . . Yes No
    b. Other stomach or intestinal problems:____________________________________
11. Do you have, or have you ever had ***endocrine problems***?
    a. Thyroid problems. . . . . Yes No
    b. Cortisone or steroid treatments. . . . . .Yes No
    c. Pheochromocytoma. . . . . Yes No
12. Do you smoke? If yes, how much per day?_______________________________Yes No
13. Do you drink alcohol? If yes, how much per day?__________________________Yes No

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14. Have you ever been diagnosed with glaucoma? . . . . Yes No
15. Have you ever experienced tonsillitis? . . . . Yes No
16. Sinus trouble, hay fever, hives, skin rash? . . . . Yes No
17. Fainting spells, seizures, or epilepsy? . . . . Yes No
18. Have you had, or do you have a serious viral illness?. . . . . Yes No
19. Hypoglycemia or low blood sugar? . . . . Yes No
20. Diabetes or high blood sugar? . . . . Yes No
21. Arthritis or inflammatory rheumatism? . . . . Yes No
22. Gout? . . . . Yes No
23. Persistent cough or cough up blood?. . . . . Yes No
24. Stroke? If yes, when?__________________. . . . . Yes No
25. Sexually transmitted disease? If yes, when treated?_____________________. . . . . . Yes No
26. Do you have an autoimmune disorder? . . . . Yes No
27. Have you had abnormal bleeding or any problems associated
    with previous tooth removal or oral surgery?. . . . . Yes No
28. Have you had any head, neck, or jaw injuries? . . . . Yes No
29. Have you experienced any ***problems in your jaw***?
    a. Clicking. . . . . Yes No
    b. Pain in the joint, ear, or side of face. . . . . Yes No
    c. Difficulty opening or closing your mouth, or chewing. Yes No
30. Please list any other diseases, illnesses, or health problems not covered above:____________________

____

31. Please circle any of the following drugs you are currently taking:

Antibiotics or sulfa drugs	Anticoagulants (blood thinners)	Birth control pills
Blood pressure medicine	Cortisone (steroids)	Antihistamines
Tranquillizers or sedatives	Insulin or diabetes drugs	Antidepressants
Thyroid medication	Digitalis, Nitroglycerin, or other heart medication	

32. List all medications and herbal substances you are currently taking:____________________________

____

33. List all medications and herbal substances that you have taken within the past month but are not taking now:____

34. List all surgeries, x-ray or radiation treatment for **a tumor, growth** or other condition:_____________

____

35. Are you allergic to or have you had a bad reaction to any of the following:

a. Local anesthetics	Yes	No	f. Penicillin or other antibiotics	Yes	No
b. Aspirin	Yes	No	g. Barbiturates or sleeping pills	Yes	No
c. Iodine	Yes	No	h. Codeine or other narcotics	Yes	No
d. Sulfa drugs	Yes	No	i. Steroids	Yes	No
e. Pain medication	Yes	No	j. Eggs	Yes	No

36. Please list all allergies you have:____

____

37. **Women:** Are you or might you be pregnant? . . . . Yes No

______________________________ ______________________________
Signature of Patient, Parent or Guardian *Date*

______________________________ ______________________________
Signature of doctor *Date*

Approved for surgery_______________Requires medical or medication consultation________________