HEALTH QUESTIONNAIRE

DATE	NAME		
SEX	HEIGHT	WEIGHT	AGE

PLEASE ANSWER EACH QUESTION — CHECK ONE: YES / NO

1. Have you been a patient in a hospital during the past 10 years for any serious illness or operations? ☐ ☐
2. Have you been under the care of a physician during the past 2 years? ☐ ☐
   If so, what for?
   Name and address of the physician
3. Have you taken any kind of medicine or drugs during the past year? ☐ ☐
   If so, please name them (including herbs & vitamins)
   Do you take anti-coagulants? (blood thinners) ☐ ☐
   Do you take steroids (cortisone)? ☐ ☐
   Do you take blood pressure medicine? ☐ ☐
4. Are you allergic to penicillin or any drugs or medicines? ☐ ☐
   If so, what type of reaction do you have?
5. Have you ever had excessive bleeding ☐ ☐
6. Do you smoke tobacco, use e-cig/vapor cigarettes or chew tobacco? ☐ ☐
   If so, how many years? .... How many packs per day? ....
7. Have you had any of the following: (if so, check those you have had)
   ☐ heart disease/attack ☐ asthma/emphysema ☐ cancer/chemotherapy/radiation ☐ stroke
   ☐ congenital heart disease ☐ chronic cough/tuberculosis ☐ arthritis ☐ allergy
   ☐ angina/palpitations/ pacemaker/heart surgery ☐ diabetes/hyperglycemia/ hypoglycemia ☐ sinus trouble/sleep apnea/ CPAP ☐ high blood pressure/ high cholesterol
   ☐ epilepsy/seizures ☐ ulcers/IBS/colitis/ acid reflux ☐ anemia/blood transfusion/ bleeding disorder ☐ hepatitis/jaundice
   ☐ psychiatric treatment ☐ venereal disease ☐ rheumatic fever ☐ mitral valve prolapse
8. (Women) Are you pregnant or nursing? ☐ ☐
9. Have you ever been diagnosed with Sleep Apnea? ☐ ☐
   Do you use a CPAP machine or supplemental oxygen at night? ☐ ☐
10. Does your jaw snap or pop? ☐ ☐
    Has it ever locked open or shut? ☐ ☐
    Do you grind or clench your teeth? ☐ ☐
11. Have you used any street/recreational drugs in the past 3 months? (including Cocaine) ☐ ☐
    If so, what type?
    Have you ever been through treatment for addiction to alcohol/drugs? ☐ ☐
12. The 1992 Americans with Disabilities Act ruling allows that the answer of the following is optional:
    Are you HIV positive? ☐ ☐
    Have you been diagnosed with AIDS? ☐ ☐
13. Have you ever taken prescription medication for weight reduction? ☐ ☐
    If YES, did you take any of the drugs listed below? (Please check those you have)
    ☐ Fen-Phen (fenfluramine + phentermine) ☐ Pondimin (fenfluramine) ☐ Redux (dexfenfluramine)
    If you have ever taken any of the above drugs, have you had a medical exam to ensure that your heart valves were not affected? ☐ ☐
14. Do you have any **JOINT OR VALVE REPLACEMENTS**? ☐ ☐
    If yes, please note what was replaced and when.

If you are completing this form for another person, what is your relationship to that person? ____________________

Signature ____

Reviewed by: ____

Woodinville Oral & Maxillofacial Surgery, Inc.

I CONSENT TO DISCLOSURE OF PERTINENT HEALTH INFORMATION TO PERSONS INVOLVED IN MY CARE

INITIALS __________

Have you ever taken a Bisphosphonate prescription medication for bone density?

Yes ☐ No ☐

(If yes, please indicate with an "X" in box)

- ☐ Didronel
- ☐ Skelid
- ☐ Fosamax
- ☐ Actonel
- ☐ Boniva
- ☐ Aredia
- ☐ Zometia

Patient Signature ______________________Date ________________

Printed Name____

Prescription refills should be requested between 9am-4pm Monday thru Friday, except for Wednesdays, those hours are 10am-2pm. Lost or stolen prescriptions will not be refilled. Many narcotic prescriptions require a written and signed form.

Washington state tracks all prescriptions and retains them in their data base.