

HEALTH QUESTIONNAIRE

For optimal safety, it is necessary that you answer the following questions.
This information will be held in utmost confidence.

Patient's Name: _____ DOB _____ Date _____

HAVE YOU EVER HAD OR HAVE YOU NOW: (Answer all questions by circling Yes (Y) or No (N))

Recent illness (within one year).....	Y	N	Hemophilia (Bleeding Disorder).....	Y	N	Kidney problems.....	Y	N
Cough, cold or flu (within two weeks).....	Y	N	Bruise or bleed easily.....	Y	N	Blood vessel grafts.....	Y	N
Nose obstruction.....	Y	N	Heart problems or chest pains.....	Y	N	Sexually Transmitted disease.....	Y	N
Shortness of breath.....	Y	N	Heart Attack.....	Y	N	Diabetes.....	Y	N
Epilepsy or Seizure.....	Y	N	Irregular heart beat.....	Y	N	Thyroid disease (Goiter).....	Y	N
Fainting or Dizziness.....	Y	N	Hypertension (High blood pressure).....	Y	N	AIDS / HIV positive.....	Y	N
Depression.....	Y	N	Rheumatic fever.....	Y	N	Arthritis.....	Y	N
Psychiatric Treatment.....	Y	N	Heart murmur.....	Y	N	Painful joints (incl. jaw).....	Y	N
Stroke.....	Y	N	Mitral valve prolapse.....	Y	N	Prosthetic joint(s) - artificial.....	Y	N
Glaucoma.....	Y	N	Congenital heart lesions.....	Y	N	Hives (allergic rash).....	Y	N
Cold sores (Herpes).....	Y	N	Heart surgery.....	Y	N	Steroid medication(s) - cortisone.....	Y	N
Persistent cough.....	Y	N	Prosthetic heart valve(s).....	Y	N	Drug addiction.....	Y	N
Emphysema.....	Y	N	Pacemaker.....	Y	N	Alcoholism.....	Y	N
Tuberculosis / PPD Positive.....	Y	N	Blood transfusion(s).....	Y	N	Unexplained weight change.....	Y	N
Asthma.....	Y	N	Liver disease (Cirrhosis).....	Y	N	Mono.....	Y	N
Bronchitis.....	Y	N	Yellow jaundice.....	Y	N	Cancer / radiation therapy.....	Y	N
Sinus problems.....	Y	N	Hepatitis - type:.....	Y	N	Headaches (Migraine).....	Y	N
Anemia.....	Y	N	Snoring / Sleep Apnea.....	Y	N	Eating Disorder.....	Y	N
Sickle Cell Disease.....	Y	N	Stomach Ulcers or Colitis.....	Y	N	Anxiety.....	Y	N

1. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE?..... Y N
IF YES, PLEASE DESCRIBE: _____
2. HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD?..... Y N
3. HAVE YOU EVER BLED EXCESSIVELY AFTER A CUT OR SURGERY? HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?..... Y N
4. DO YOU HAVE CLICKING OR POPPING OF THE JAW JOINT, PAIN NEAR THE EAR, DIFFICULTY OPENING MOUTH, GRIND OR CLINCH TEETH?. Y N

FOR WOMEN ONLY: (Circle)

- A. Are you Pregnant, or **is there any chance** you might be pregnant?..... Y N
- B. Are you nursing?..... Y N
- C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

We must emphasize the seriousness of surgery or anesthesia during pregnancy (especially early pregnancy) including harm to fetus.

ALL patients please continue on with the following information

Date of your last physical exam _____ Last EKG _____

Are you now under a physician's care or have you been during the past 5 years including hospitalization(s)?..... Y N

If yes, for what? _____

Describe any complications: _____

Have you ever gone to sleep for an operation? (If yes, please list operation and date) Y N

Describe any complications: _____

OVER



Have you or an immediate family member ever had any serious problems associated with anesthesia?..... Y N

Are you now taking medicine of any kind? (including Blood Thinners, Aspirin, Inhalers, Ibuprofen, Vitamins, over-the-counter supplements)..... Y N

If yes, list medications and dosage (please include over the counter, herbal or homeopathic preparations): _____

Have you ever taken any bisphosphonate drugs including the following: Alendronate (Fosamax), Etidronate (Didronel), Pamidronate (Aredia), Risedronate (Actonel), Tiludronate (Skelid), Zoledronic Acid (Zometa) or (Reclast), Clodronate (Bonefas) or Ibandronate (Boniva) -

These drugs increase your risk for poor bone healing after surgery Y N

Do you now or have you ever used recreational drugs? (Cocaine, Marijuana, etc.) Y N

Please list as they can be dangerous in conjunction with anesthetic drugs: _____

Is there anything you would like to discuss in private with Dr. Satterfield?..... Y N

Would you like for Dr. Satterfield to pray for you before any needed surgery? Y N

What is your occupation? _____ **If a student, what school and grade?** _____

ANY FAMILY HISTORY OF:

SOCIAL HISTORY:

Heart Disease	Y	N	Diabetes	Y	N	Smokeless tobacco usage?	Y	N	_____ yrs.		
Cancer	Y	N	Seizures	Y	N	Smoke?	Y	N	How long _____ yrs. Pks. per day _____		
Bleeding Disorder	Y	N	Stroke	Y	N	Alcohol consumption (circle):	None	Mild	Moderate	Daily	How long _____ yrs.

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

Local Anesthesia (Novacain, etc.)?	Y	N	Codeine or other pain killers?	Y	N
Sedatives, Barbiturates?	Y	N	Latex or Rubber products?	Y	N
Aspirin or Ibuprofen?	Y	N	Metal of any kind?	Y	N
Penicillin?	Y	N	Chemicals or jewelry (rash or sensitivity)?	Y	N
Other Antibiotics? Please list _____	Y	N	Food products?	Y	N
			Other allergies or reactions? Please list _____	Y	N

Do you wear dentures Y N

Do you wear contact lenses Y N

I certify that I fully understand the questions contained in this health history and certify that the answers are truthful and accurate.

_____	_____	_____
Date	Signature of Person Completing Health History (must be 18 years old)	Doctor's Initials

Your relationship to the patient (if you signed for the patient) _____

BP _____ Pulse _____ Sex _____ Weight _____ Height _____ Temp _____

MEDICAL UPDATE: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

_____	_____	_____	_____
Date	Exceptions or changes	Patient's Signature	Doctor's Initials

OFFICE NOTES
