DENTALNI
KIRURŠKI
ESTETSKI
D CENTER

Celovški dvori
Rakuševa ulica 6
1000 Ljubljana

HEALTH QUESTIONNAIRE

Although as maxillofacial surgeons we primarily treat the area in the head and neck, we need to review your overall general health. Any medical problems that you may have, or medications prescribed by other providers, can significantly affect the care we provide. We are required by law to maintain the privacy of your health information and we will use it only in your treatment unless you authorize otherwise.

D CENTER

Chart No: .....

PLEASE FILL IN

Name and surname: .....

Address: .....

.....

Birth date: .....

Phone number: .....

E-mail: .....

I was referred to D Center by: .....

.....

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hepatitis or Jaundice
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Immunosuppressive Conditions
- ☐ Latex Allergy
- ☐ Pneumonia
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Thyroid Condition
- ☐ Tuberculosis

Other .....

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Turn and continue >>

PLEASE ANSWER THE FOLLOWING QUESTIONS "YES" OR "NO." IF YOUR ANSWER TO ANY QUESTION IS "YES," PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED BELOW:

01. Are you having surgery today? ☐ YES ☐ NO
    a. If yes, have you had anything to eat or drink in the last 8 hours, including gum, candy or water? ☐ YES ☐ NO
    b. If yes, do you have someone to drive you home & stay with you? ☐ YES ☐ NO
02. Have you ever been pre-medicated with antibiotics prior to a dental procedure? _____
03. Do you have any allergies to medications? ☐ YES ☐ NO
04. Are you allergic to eggs or soy? ☐ YES ☐ NO
05. Do you have any other food allergies? ☐ YES ☐ NO
06. Do you have an artificial joint or implant in your hips, knees, shoulders, etc.? ☐ YES ☐ NO
07. Have you ever had complications from general anesthesia or dental treatment? ☐ YES ☐ NO
08. Are you currently taking any medications prescribed by a doctor? ☐ YES ☐ NO
    If yes, which one? _____

    _____

09. Do you have inflamed areas, growths or sore spots in or around your mouth? ☐ YES ☐ NO
10. Do you have any unhealed injuries? ☐ YES ☐ NO
11. Are you being treated by a physician for any chronic medical problems? ☐ YES ☐ NO
12. Have you ever been hospitalized? ☐ YES ☐ NO
13. Do you have a cold or sore throat now? ☐ YES ☐ NO
14. Do you have clicking, popping or pain in your jaw joints? ☐ YES ☐ NO
15. Do you have frequent or severe headaches? ☐ YES ☐ NO
16. Do you have any vision impairment or hearing loss? ☐ YES ☐ NO
17. Has a physician told you that you have a heart murmur or heart disease? ☐ YES ☐ NO
18. Have you had a heart attack? ☐ YES ☐ NO
19. Have you had a heart valve repair or replacement? ☐ YES ☐ NO
20. Are your ankles often swollen? ☐ YES ☐ NO
21. Do you get short of breath, even without exertion? ☐ YES ☐ NO
    a. Asthma? ☐ YES ☐ NO
    b. Sleep Apnea? ☐ YES ☐ NO
22. Do you currently have a cough or chest congestion? ☐ YES ☐ NO
23. Do you smoke or chew tobacco? ☐ YES ☐ NO Quantity: _____ Frequency: _____
24. Do you have stomach or bowel problems? ☐ YES ☐ NO
25. Do any medications make you nauseated? ☐ YES ☐ NO
26. Has a physician told you that you have kidney disease? ☐ YES ☐ NO
27. Are you frequently thirsty? ☐ YES ☐ NO
28. Do you have a bleeding disorder or blood disease? ☐ YES ☐ NO
29. Have you ever had severe bleeding after dental extractions or cuts? ☐ YES ☐ NO
30. Do you take blood thinning medication such as Coumadin? ☐ YES ☐ NO
31. Have you ever fainted? ☐ YES ☐ NO
32. Have you ever had a seizure? ☐ YES ☐ NO Date of last seizure: _____
33. Are you taking anti-seizure medications? ☐ YES ☐ NO
34. Have you ever had radiation therapy or chemotherapy? ☐ YES ☐ NO
35. Are you taking osteoporosis medications such as Fosamax, Bonviva or Aredia? ☐ YES ☐ NO
36. Are you nursing? ☐ YES ☐ NO
37. Is there a possibility you are pregnant? ☐ YES ☐ NO Estimated due date: _____
38. Are you taking birth control pills, DepoProvera or using a patch? ☐ YES ☐ NO
39. Do you take any medications for anxiety or sleeplessness? ☐ YES ☐ NO

Any Other Medical Concerns: _____

_____

_____

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

Patient Signature

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