TRI-COUNTY
Oral Facial Surgeons, P.C.

HEALTH QUESTIONNAIRE

To Our Patients

Health problems that you may have or medications that you are taking could have an important relationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records and will be considered confidential.

Name (Last, First, MI) _____ Social Security # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zipcode _____

Preferred Phone Number (Indicate Cell, Home, or Work) _____ Secondary Phone Number (Indicate Cell, Home, or Work) _____

Family Dentist _____ Date of Last Visit _____ PCP – Medical Doctor _____ Date of Last Visit _____

Reason for Today's Visit _____ Height _____ Weight _____

Female Patients

Are you currently taking Birth Control? ☐ YES ☐ NO

Is there a possibility you may be pregnant? ☐ YES ☐ NO Expected Due Date _____

Are you nursing? ☐ YES ☐ NO Age of Child _____

Male Patients

Any prostate problems? ☐ YES ☐ NO

Current Medical History

Have you had any illness, operation or been hospitalized in the past five years? ☐ YES ☐ NO

Do you have any current diseases or conditions? If so, please list below. ☐ YES ☐ NO

Current Diseases or Conditions _____

Medication

Are you currently taking any medications? ☐ YES ☐ NO

If yes, please list any and all medications that you are currently taking (including prescriptions, over the counter, vitamins, or herbal)

Medication Name _____ Dosage/ Frequency _____

Medication Name _____ Dosage/ Frequency _____

Medication Name _____ Dosage/ Frequency _____

Allergies

Do you have any allergies? ☐ YES ☐ NO

Are you allergic to or ever had a reaction to any Local Anesthesia? ☐ YES ☐ NO

Are you allergic to? (check all that apply)

☐ LATEX ☐ ASPIRIN ☐ EGGS ☐ IV CONTRAST ☐ SHELLFISH ☐ PENICILLIN/AMOXICILLIN

☐ CODEINE ☐ SOY ☐ PEANUTS ☐ TREE NUTS ☐ OTHER _____

State College
200 W. Beaver Ave, Suite 100
State College, PA 16801
1.800.446.5680

www.TriCountyOMS.com

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Social History

Do you live alone? ☐ YES ☐ NO

Currently employed? ☐ YES ☐ NO

Do you consume alcohol? ☐ YES ☐ NO How much? _____

Marital Status ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Tobacco History

Do you **currently** smoke or use smokeless tobacco? ☐ YES ☐ NO

How much (packs or cans per day)? ☐ ONE ☐ TWO ☐ OTHER _____

Have you ever smoked or used smokeless tobacco in the **past**? ☐ YES ☐ NO

Family History (check all that apply)

☐ HEART DISEASE ☐ STROKE ☐ ASTHMA ☐ CANCER ☐ DIABETES ☐ HIGH BLOOD PRESSURE

Have you had or do you currently have		YES	NO	Have you had or do you currently have		YES	NO
CARDIO/	High Blood Pressure			NEURO	Seizures/Convulsion		
(HEART)	Stent or Cardiac Surgery				Stroke/Paralysis/TIA		
	Abnormal pulse/rhythm			METABOL	Diabetes:Type I/Type II		
	Congestive Heart Failure(CHF)			ENDO	Controlled:Meds/Diet/Insulin		
	Atrial Fibrillation (A-fib)				Thyroid Disorder Hypo/Hyper		
	Coronary Artery Disease(CAD)				Adrenal Problems		
	Ankle swelling/Edema			GI	Ulcers		
	Peripheral Vascular Disease				Ulcerative Colitis		
	Elevated Cholesterol			DIGESTIV	Nausea/ Vomiting		
	Circulatory – murmur/valve				Hiatal Hernia		
	Angina (chest pain)				GERD/Acid Reflux		
	Palpitations				Liver Disease		
	Heart Attack				Irritable Bowel Syndrome		
	History of Rheumatic Fever				Crohn's Disease		
	Echocardiogram			EYE/EAR	Difficulty Swallowing		
	Stress test			NOSE/THR	Removable Dental Appliance		
	xxxxxxxxxxxxxxxxxxxxxx				Hearing Impairment		
RESPIRA/	Asthma				Glaucoma		
(LUNG)	Emphysema (COPD)				Macular Degeneration		
	Bronchitis				Cataracts		
	Tuberculosis			KIDNEY	Kidney infections		
	Daily Cough				Kidney Failure/Dialysis		
	Productive Cough				Kidney Stones		
	Shortness of breath (SOB)			BLOOD	Anemia		
	Wheezing				Abnormal blood count		
	Trouble going up stairs				Bleeding Tendencies		
SKELETAL	TMJ			ANESTHESIA	Complications with Anesthesia		
	Back Problems				Unusual reactions to Anesthesia		
	Arthritis				Malignant Hyperthermia		
	Osteoporosis				Sleep Apnea		
	Neck Mobility				Use Oxygen at home/at night		
	Joint pain/swelling				Loud snoring		
	Prolong Prednisone/Steroid use				Use CPAP/BIPAP at night		
	Artificial Replacements			PSYCHOLO	Depression		
CANCER	Cancer				Anxiety/Nervousness		
	Chemotherapy				Bipolar		
	Radiotherapy				Schizophrenia		

I certify that I read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient or Parent/Guardian if Minor _____ Date _____ Time _____

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