Advanced Oral and Facial Reconstructive Surgery

Gilbert T. Selkin, MD, DMD

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Please answer ALL the following questions and fill in the blanks where indicated. This questionnaire is for our records only and is considered confidential.

1. Are you in good health? ---------- Yes No
2. Your last physical examination was on (date):
   _____
3. Are you under the care of a physician? ---------- Yes No
   If so, what is the condition that is being treated?
   _____
   Name and telephone number of the physician:
   _____
4. Do you have a cardiologist? ---------- Yes No
   Name and telephone number of the cardiologist: _____
   _____
5. Have you had any serious illnesses, operation, or been hospitalized? ---------- Yes No
   If yes, what was the problem and when?
   _____
   _____
6. Are you pregnant? ---------- Yes No
7. Do you drink alcoholic beverages? ---------- Yes No
   If yes, how many per week?
   _____
8. Do you smoke or use tobacco products? ---------- Yes No
   If yes, how many cigarettes per day?
   _____
9. Do you use any recreational drugs? ---------- Yes No
   If yes, what kind? _____
10. Do you use marijuana? ---------- Yes No
    If yes, how many times per week?
    _____
11. Do you take vitamins and/or supplements? ------ Yes No
12. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? -- Yes No
13. Do you bruise easily? ---------- Yes No
14. Have you ever required a blood transfusion?----- Yes No
    If yes, explain circumstances:
    _____
    _____
15. Do you have any bleeding disorder (such as anemia)? ---------- Yes No
16. Are you taking any drug or medicine? --------- Yes No
    List all drugs, medications, or supplements you are currently taking:

    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____

17. Are you taking any of the following?
    a. Antibiotics or sulfa drugs ---------- Yes No
    b. Anticoagulants (blood thinner) ---------- Yes No
    c. Aspirin ---------- Yes No
    d. Cortisone (steroids) ---------- Yes No
    e. Digitalis or drugs for heart problems Yes No
    f. Fish oil ---------- Yes No
    g. Insulin ---------- Yes No
    h. Medicine for anxiety or depression —---- Yes No
    i. Medicine for high blood pressure -------- Yes No
    j. Nitroglycerin ---------- Yes No
    k. Tranquilizers ---------- Yes No
18. Are you taking or have you ever taken:
    a. Osteoporosis medications (Fosamax, Actonel, Aredia, Boniva, Didronel, Skelid, Bonefos, or Zometa) ---------- Yes No
    b. PROLIA for osteoporosis, or chemotherapy for Multiple Myeloma, etc. ---------- Yes No
    c. Fen-Phen or related drug such as lonimin, Adipex, Phentramine, Fastin, Pondimin (fenfluramine), and Redux (dexfenfluramine)---------- Yes No
19. Are you **ALLERGIC** to any medications? ------- Yes No
    If yes, what are you allergic to?
    _____
    _____

20. Are you allergic or have you reacted adversely to:
    a. Aspirin ----------
    b. Barbiturates, sedatives, sleeping pills - Yes No
    c. Iodine ----------Yes No
    d. Latex ----------Yes No
    e. Local Anesthetic ---------- Yes No
    f. Penicillin or other antibiotics ----------Yes No
    g. Soybean or egg ----------Yes No
    h. Sulfa drugs ---------- Yes No
    i. Other (Please write below): ----------Yes No
    _____Yes No
21. Do you grind your teeth at night? ----------
22. Do you have a history of jaw pain when Yes No opening and closing? ----------
23. Does your jaw pop or click when opening?- Yes No
24. Has your jaw ever been stuck open or Yes No closed? ----------
25. Have you had surgery or x-ray treatment Yes No for a tumor, growth or other condition in your mouth or on your lips? ----------
26. Have you had any adverse reaction Yes No associated with previous dental treatment? ----------
    If yes, please explain: Yes No
    _____
    _____
    _____
27. Have you had any adverse reaction associated with previous medical treatment or surgery? ----------
28. Have you had any adverse reaction or Yes No family history of adverse reaction to anesthesia? ----------
29. Have you ever received any radiation Yes No treatment to the jaws or any area of the head and neck for any reason? ----------
    If yes, what was the body location where Yes No radiation was performed?
    _____
    When was treatment?
    _____
    Doctor who performed the treatment?
    _____

30. Have you had any of the following conditions?
    a. ADHD ---------- Yes No
    b. AIDS ---------- Yes No
    c. Allergies ---------- Yes No
    d. Anaphylaxis ---------- Yes No
    e. Anemia ---------- Yes No
    f. Angina ---------- Yes No
    g. Anxiety ---------- Yes No
    h. Arthritis ---------- Yes No
    i. Artificial Joint Replacement ---------- Yes No
    j. Asthma ---------- Yes No
    k. Autism Spectrum Disorder ---------- Yes No
    l. Bipolar Disorder ----------Yes No
    m. Blood Clot ---------- Yes No
    n. Cancer ---------- Yes No
    o. Depression ---------- Yes No
    p. Diabetes ---------- Yes No
       If yes, what is your current A1C?
       _____
    q. Drug/Alcohol Addiction ---------- Yes No
    r. Emphysema ----------Yes No
    s. Epilepsy ---------- Yes No
    t. Fainting ----------Yes No
    u. Glaucoma ----------Yes No
    v. Heart Attack ----------Yes No
    w. Hepatitis ---------- Yes No
    x. High Blood Pressure ----------Yes No
    y. HIV Positive ---------- Yes No
    z. Immunosuppression ---------- Yes No
    aa. Kidney Disease ---------- Yes No
    bb. Liver Problem ----------Yes No
    cc. Low Blood Pressure ---------- Yes No
    dd. Lung Disease ----------Yes No
    ee. Mental Illness ----------Yes No
    ff. Rheumatic Fever ----------Yes No
    gg. Stroke ----------Yes No
    hh. Thyroid ---------- Yes No
    ii. Tuberculosis ----------Yes No
    jj. Venereal Disease ---------- Yes No
    kk. Other (please write below): ----------Yes No
    _____
    _____
    _____

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware.

Signature of Patient/Legal Guardian: _____ Date: _____

I have reviewed the health history form above.

Signature of Dr. Gilbert Selkin: _____ Date: _____