IMPACT
oral surgery

HEALTH QUESTIONNAIRE

Please mark all that apply.

1. CARDIOVASCULAR DISEASE

- High Blood Pressure
- Low Blood Pressure
- Arteriosclerosis
- Heart Attack
- Heart Bypass Surgery
- Prosthetic Heart Valves
- Congenital Heart Malformations
- Hypertrophic Cardiomyopathy
- Mitral Valve Prolapse
- Heart Murmur
- Rheumatic Fever
- Bacterial Endocarditis
- Heart Stents or Shunts
- Osteoporosis
- Other

2. OTHER

- Diabetes, taking insulin?
  Insulin name: _______________
- Blood transfusion since 1980?
- Hepatitis: A __ B __ C __
- Jaundice, liver disease
- Stomach Ulcers
- Kidney Problems
- Arthritis or Rheumatism
- Tuberculosis
- Venereal Disease or AIDS virus
- Abnormal Bleeding
- Anemia
- Cancer: Radiation / Chemotherapy
- Have you had any joint replacements?
- Are you pregnant? How many months? _____
- Sinus trouble
- Hay Fever
- Asthma
- Cocaine use
- Stroke
- Angina / Chest Pain
- Irregular Heart Beat
- Pacemaker / Implanted Defibrillator
- Autoimmune Disease / Lupus
- Thyroid Disease
- Organ Transplant
- Epilepsy / Seizure
- Psychiatric Treatment
- Emphysema / Bronchitis
- Other

3. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Penicillin / Antibiotics
- Sulfa Drugs
- Codeine
- Iodine
- Aspirin
- Local Anesthetic

HUGH F. BURNETT III, DDS • JOSHUA LEAL, DDS
501.408.4774 • 844.672.2867
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4. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

- Sulfa Drugs
- High Blood Pressure
- Tranquilizers
- Aspirin
- Antihistamines
- Cortisone
- Digitalis
- Drugs for Heart Disease
- Antibiotics
  - Names of Antibiotic: ______________________
  - Date Started: ____________________________
- Vitamins and/or Herbals
- Appetite Suppressants

List any other medications you are taking currently:

____

____

____

5. Are you taking any of the following medications: Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefos, Zometa?

____

____

____

6. Have you had any problems associated with previous dental treatment?

____

____

____

7. Have you had any serious illness or operations in the past?

____

____

____

Please sign your name and date this after reading and completing this form.

____

Signature | Date

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