

JOHNSON ORAL SURGERY
MATTHEW J. JOHNSON, MD, DMD

HEALTH QUESTIONNAIRE

NAME _____ SOCIAL SECURITY # _____

AGE _____ SEX _____ HEIGHT _____ WEIGHT _____ DOB _____

****Are you Allergic to any Medications or Latex** YES NO

If yes, please list _____

Please Circle **YES** or **NO**

1. Has there been any change in your health in the past year? YES NO
 If yes please explain _____

2. Are you now under the care of a physician? YES NO

3. Have you had any serious illness or operation? YES NO

4. Have you been hospitalized in the last 5 years? YES NO
 If yes please explain _____

5. Have you had any abnormal bleeding or any other problem associated
 With previous tooth removal or oral surgery YES NO

6. Do you take any herbal medication or supplement? If so, what and how often?

Please circle any of the following drugs you are currently taking:

- | | |
|-------------------------------|--|
| a. Antibiotics or Sulfa drugs | g. Anticoagulants (blood thinners) |
| b. Blood pressure medication | h. Cortisone (steroids) |
| c. Tranquilizers or sedatives | i. Insulin or Diabetic drugs |
| d. Thyroid medication | j. Digitalis, Nitroglycerin, or other heart meds |
| e. Aspirin | k. Birth control pills |
| f. Antihistamines | l. Antidepressants |

7. List all other medications you are taking now or have taken within the last month

8. List all surgeries, x-ray or radiation treatment for tumors, growths, or other conditions

Please **CIRCLE** if you have now, or have **EVER** had problems with and/or treatment for the following:

Heart Problems Congenital Heart Lesions Heart Murmur Asthma

Heart Attack High or Low Blood Pressure Diabetes Hepatitis

Sleep Apnea Anemia Breathing Problems Arthritis TMJ

Drug/Alcohol Use Sinus Trouble Hepatitis Stroke Rheumatic Fever

Tuberculosis Jaundice Epilepsy Psychiatric Treatment Kidney Problems

Sexually Transmitted Disease Immune System Disorder or Auto Immune Disease

****If you circled any of the above conditions, Please explain in detail**

Please list any other Health Conditions, Diseases, or Problems not covered above

WOMEN: Are you now or might you be pregnant YES NO

Signature of patient, parent, or guardian

Date

Signature of Doctor

Date