PRESURGERY QUESTIONNAIRE

Name: _____

Procedure: _____

Date and Time: _____

This procedure has been carefully planned to minimize the risk of complications. To help us optimize the outcome of your procedure, please carefully fill out this questionnaire.

Are you allergic to Novocain or Xylocaine? ____ Yes ____ No

Please list any known drug allergies: _____

Are you currently taking any medication for: (check all that apply)

____ Arthritis ____ Depression/Nervousness ____ Blood Thinners

____ Aspirin (Why?) _____

Do you require antibiotics prior to dental procedures or surgery? ____ Yes ____ No

Please list all medications: _____

_____

If female, are you pregnant? ____ Yes ____ No

Do you drink alcohol or beer? ____ Yes ____ No How much? _____

Do you smoke? ____ Yes ____ No How much? _____

Have you ever had any of the following: (circle all yes or no)

YES	NO	Reaction to anesthesia	YES	NO	Fainting and dizzy spells
YES	NO	Liver disease, hepatitis, jaundice	YES	NO	Psychiatric or nerve problems
YES	NO	Bleeding disorder, easy bruising	YES	NO	Diabetes
YES	NO	Pacemaker	YES	NO	Artificial heart valves
YES	NO	Keloids or large scars after surgery	YES	NO	Herpes, cold sores, fever blisters
YES	NO	Blood transfusion in the past	YES	NO	AIDS or HIV
YES	NO	Recent artificial joint			

Do you have any other medical problems we should know about? ____ Yes ____ No

If so, please explain: _____

_____

Patient Signature: _____ Date: _____