SOUTH RIDING
ORAL & IMPLANT SURGERY

Please answer all questions by circling the best response. Your doctor will discuss your answers with you.

Name (First, Last): _____ Date of Birth: _____

Gender: M / F How do you identify: _____ Preferred Pronouns: _____

Is your health good at present?	Yes	No	If no, explain: _____
Are you under the care of a physician?	Yes	No	If so, why? _____
Have you been admitted to a hospital?	Yes	No	If so, why? _____
Have you had surgery before?	Yes	No	

Procedure: _____

Complications: _____

Check all that apply.

Heart Problems:
- ☐ Heart Attack/MI
- ☐ Angina/Chest Pain
- ☐ High Blood Pressure
- ☐ Prosthetic heart valve
- ☐ Congestive heart failure
- ☐ Heart Bypass/stent surgery
- ☐ Congenital heart defect
- ☐ Pacemaker/defibrillator
- ☐ Infective endocarditis
- ☐ Heart palpitations/Irregular heartbeat
- ☐ Rheumatic fever/rheumatic heart disease

Breathing Problems:
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Sleep apnea
- ☐ Bronchitis/Emphysema/ COPD
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Pneumonia

Blood Problems:
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ HIV disease/AIDS
- ☐ Bleeding disorders (e.g. Hemophilia)
- ☐ Coumadin/Warfar treatment
- ☐ Bruising easily

Head, Eyes, Ears, Nose & Throat:
- ☐ Frequent Headache
- ☐ Jaw joint/TMJ popping, catching, pain
- ☐ Glaucoma
- ☐ Sinus or nasal problem

Digestive Problems:
- ☐ Hepatitis/Jaundice
- ☐ Liver disease
- ☐ GERD/reflux/ulcers

Endocrine Problems:
- ☐ Diabetes
- ☐ Thyroid Disorders

Nervous System Problems:
- ☐ Stroke/TIA/mini-stroke
- ☐ Epilepsy/seizure disorder
- ☐ Neuropathy/nerve pain

Psychiatric Problem:
- ☐ Depression
- ☐ Panic or anxiety disorder
- ☐ Other: _____

Other Problems:
- ☐ Renal/Kidney Disease
- ☐ Organ transplant
- ☐ Cancer
- ☐ Radiation or chemotherapy treatment
- ☐ Arthritis
- ☐ Artificial joint/joint Replacement
- ☐ Other: _____

For WOMEN only:
- ☐ Are you nursing Y/N
- ☐ Are you pregnant Y/N

Dental Surgery:
- ☐ Anxiety about having dental work
- ☐ Have difficulty getting numb

Family History:
- ☐ Cancer
  Relationship: _____
- ☐ Arthritis
  Relationship: _____
- ☐ Heart Disease
  Relationship: _____
- ☐ Hypertension
  Relationship: _____
- ☐ Anesthesia complications
  Relationship: _____

Social History:
- ☐ Smoking/tobacco use
  Type, Duration, Frequency
  _____
- ☐ Alcoholic beverages
  Type, Duration, Frequency
  _____
- ☐ Recreational (street) drugs
  Type, Duration, Frequency
  _____

Are you ALLERGIC to any of the following: (include reaction if known)
- ☐ Aspirin
- ☐ Pain medicine(s)
- ☐ Penicillin/Amoxicillin
- ☐ Other antibiotics: _____
- ☐ Local anesthetics
- ☐ Other medicine(s) _____
- ☐ Latex or glove powder
- ☐ Environmental/seasonal
- ☐ Other allergies: _____

Are you taking any of the following medications?

- ☐ Anticoagulation medicine(s)
- ☐ Aspirin
- ☐ Coumadin
- ☐ Plavix
- ☐ Bisphophonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)

Weight:_____lbs Height: _____

List any other medications:

Supplements (diet, vitamin, natural, or herbal)

Patient/ Guardian Signature:_____Date: _____

Dr. Kamran Raja Signature:_____Date: _____