



Have you had a cough, cold or sore throat in the last 48 hours? Yes  No

Do you take aspirin (or a similar drug)? Yes  No

Do you take any medications? (prescribed, over-the-counter, or herbal) Yes  No

List of Medications (Names Only):

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

Are you a current smoker, or were you a regular smoker in the past? Yes  No

Do you use eye drops or nose drops? Yes  No

Do you wear contact lenses? Yes  No

Do you have dentures or bridges? Yes  No

Are your front teeth capped? Yes  No

Are any teeth loose, chipped or bad? Yes  No

Do you have an alcoholic drink more than once a day? Yes  No

Have you, or your relatives had an unexplained or serious complication during surgery or anesthesia? Yes  No

Have you had any previous procedures done before? If so, specify below. Yes  No

Is it possible you may be pregnant? Yes  No

***Have you had or still have any of the following problems? (Please check if applicable)***

- |  |   |
|--|---|
| <input type="checkbox"/> Ulcer, Hiatus Hernia      | <input type="checkbox"/> Anemia                 |
| <input type="checkbox"/> Blood Clots               | <input type="checkbox"/> Sickle Cell Anemia     |
| <input type="checkbox"/> Swollen, Sore Legs        | <input type="checkbox"/> Prolonged Bleeding     |
| <input type="checkbox"/> Bronchitis                | <input type="checkbox"/> Thyroid Disease        |
| <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Persistent Indigestion |
| <input type="checkbox"/> Phlegm                    | <input type="checkbox"/> Back Problems          |
| <input type="checkbox"/> Pneumonia, Lung Problems  | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Asthma, Wheezing          | <input type="checkbox"/> Weakness               |
| <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Walking Problems       |
| <input type="checkbox"/> Heart Condition           | <input type="checkbox"/> Blackouts              |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Low Blood Pressure        | <input type="checkbox"/> Dizziness              |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Blindness              |
| <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Deafness               |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Epilepsy               |
| <input type="checkbox"/> Palpitations              | <input type="checkbox"/> Meningitis/Polio       |
| <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Chest Pain, Angina        | <input type="checkbox"/> Glaucoma               |
| <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Nervous Disorder       |
| <input type="checkbox"/> Hepatitis, Liver Problems | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Bruise or Bleed Easily    | <input type="checkbox"/> Cold Sores/Herpes      |

- Venereal Disease
- Prednisone Treatment

Any other problems:

Do you have any major fears regarding your procedure?

Yes  No

***I have read and understood the above questionnaire and certify that the answers given by me (or a representative for me) are correct to the best of my knowledge.***

Patient signature: