South Florida Interventional
PATIENT QUESTIONNAIRE MEDICAL HISTORY & REVIEW OF SYSTEMS

NAME:_____ Home Phone #:_____

weight _____ pounds height _____feet _____inches

None 1. List your ALLERGIES to medications or drugs:

_____

None 2. List ALL medications you take at home (include over the counter meds):

_____

Yes No 3. Have you ever smoked? Average _____ packs per day for _____ years.
Yes No 4. Do you drink alcoholic beverages? Beer? Wine? Liquor? Amount per week?_____
Yes No 5. Have you used any recreational drug (marijuana, cocaine, LSD, etc.) within the past 14 days?
Yes No 6. Do you wear dentures? (Circle) Full set Upper only Lower only
Yes No 7. Do you wear a dental bridge? (Circle) Partial Fixed/Removable Upper/Lower/Both
Yes No 8. Do you have any crowns, capped teeth, chipped teeth, or loose teeth?
Yes No 9. Have you ever had surgery or anesthesia? Please list below:

YEAR	OPERATION	TYPE OF ANESTHESIA				COMPLICATIONS (If any)
		GENERAL	LOCAL	SPINAL	EPIDURAL	

Yes No 10. Has any blood relative ever had a complication related to anesthesia?
Yes No 11. Have you taken any of the following medications in the past week?
Aspirin Products..... Anacin, Bufferin, Excedrin, Ecotrin, etc.
Anti-Inflammatory Drugs.... Motrin, Advil, Nuprin, Ibuprofen, Naprosyn, etc.
Blood Thinning Drugs..... Coumadin, Heparin, Persantine, Lovenox
Yes No 12. Have you taken any steroid medication (Prednisone, Cortisone) in the past 6 months?
Yes No 13. Do you require antibiotics before a dental procedure? Why?_____
Yes No 14. Have you ever been transfused with blood or blood products? _____
Yes No 15. Have you ever had an adverse reaction during or after transfusion of blood or blood products?
Please describe:_____
Yes No 16. Do you have a religious objection to receiving blood products if deemed medically necessary
Yes No 17. Have you ever been treated for cancer with chemotherapy or radiation? Year:_____
Yes No 18. Have you had a cold, sore throat, runny nose, fever, cough, or flu in the past 2 weeks?
Yes No 19. Have you been treated for nervous or emotional problems (i.e., depression)?
Yes No 20. Have you ever had or been treated for HEART PROBLEMS?

Yes No	Heart Attack Year _____	Yes No	Rheumatic Fever
Yes No	Chest pain or Angina	Yes No	Leg Swelling
Yes No	Cardiac Arrest	Yes No	Fainting
Yes No	Irregular Heartbeat or Atrial Fibrillation	Yes No	Peripheral Vascular Disease
Yes No	Mitral Valve Prolapse	Yes No	Heart Murmur

Yes No 21. Have you ever had or been treated for HIGH BLOOD PRESSURE or LOW BLOOD PRESSURE?