Dr. Han Choi
ORAL & MAXILLOFACIAL SURGEON
Dr. Sam Goldsmith
ORAL SURGEON

Label

PATIENT HEALTH QUESTIONNAIRE:

TITLE: **DATE OF BIRTH:**

SURNAME: **FIRST NAME (s):**

ADDRESS:

HOME PHONE NBR: **WORK PHONE NBR:** **MOBILE:**

EMAIL ADDRESS: **OCCUPATION:**

EMERGENCY CONTACT NAME: **RELATIONSHIP:** **NUMBER:**

NORMAL DENTIST: **GENERAL PRACTITIONER:**

REFERRING PERSON: **NHI:**

HEALTH INSURER: **PLAN:** **MEMBERSHIP NBR:**

MEDICAL HISTORY: Please circle yes or no. If the answer is yes, please provide further details.

1. (a) At the present time are you taking any medication or tablets / or have you taken any medication or tablets during the last 6 months? YES/NO
   If 'YES' what are they:_____

   Reason:_____

   (b) Are you taking any Vitamins, herbal supplements or homeopathic medications YES / NO

   If 'YES' what are they: _____

   _____
2. Have you been under the care of a doctor: or in hospital during the past six months? YES/NO

   Reason:_____
3. Have you experienced any allergic/unusual effects from any tablets, drugs, injections or anaesthetic? YES/NO

   Details:_____

Please turn over

4. **Please tick if you ever have had any of the following**:

Heart trouble	☐	**Heart Murmur**	☐	**Arthritis**	☐
Asthma	☐	**Rheumatic Fever**	☐	**Jaundice or Hepatitis**	☐
Anaemia	☐	**Epilepsy**	☐	**Diabetes**	☐
Bruise Easily	☐	**Kidney Problems**	☐	**Blood Pressure High/Low**	☐
Other	☐ (please give details)				

_____

5. Do you have a bleeding problem, such as prolonged bleeding after surgery, anaemia, or bruising? YES / NO

6. **Females**: (a) are/could you be pregnant? YES / NO (b) Do you take the "pill"? YES / NO

7. Have you had any prosthetic surgery? (e.g. heart valve or joint replacement) YES / NO

8. Are you HIV positive? YES / NO

9. Are you Hepatitis "A" "B" or "C" positive? YES / NO

10. Do you smoke? YES/NO How many per day _____

11. Do you have any individual requirements? If yes, please provide more details.

Yes	**No**	
☐	☐	Language
☐	☐	Disability
☐	☐	Religious, spiritual, cultural or family / Whanau
☐	☐	Do you want your Extracted Teeth returned. Body parts: if your procedure requires the removal of a body part would you like it returned if this is possible
☐	☐	Is there anything else we need to know to help us plan your care? Please detail below. You will have the opportunity to discuss this with your Nurse / Surgeon prior to your surgery

_____

12. Health information: It may be necessary to release health information to your insurance provider / funder to obtain prior approval.

I acknowledge that my health information may need to be released to the insurance provider / funder and give my informed consent for this to occur.

Signature:_____ **Date**: _____