

PATIENT NAME: _____

DATE: _____

ORAL AND MAXILLOFACIAL PATHOLOGY
PRE-APPOINTMENT QUESTIONNAIRE

Please provide the following information:

1) List all dentists and physicians who are providing for your health care – please include telephone numbers.

First Name	Last Name	Specialty	Street Address	Telephone Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Continue on reverse side as necessary)

2) List all prescription and non-prescription drugs and dosages which you are currently receiving, and indicate starting date (year) of therapy. (Continue on reverse side as necessary)

3) Please indicate your primary pharmacy with telephone number.

4) List all surgeries and hospitalizations, with reason for service and year.
(Continue on reverse side as necessary)

5) Please answer the following questions.

A. Do you experience a rash following sun exposure (other than sunburn)?

_____ Yes _____ No

B. Do you have a skin rash? _____ Yes _____ No

C. Have you had any skin lesions removed? _____ Yes _____ No

D. Do have chronically sore joints? _____ Yes _____ No

E. Do you experience chronic pain in your muscles? _____ Yes _____ No

F. Do you experience sudden severe spasms/pain in hands/feet? _____ Yes _____ No

G. Do you experience any chronic pain or burning in any of the following areas?

_____ mouth _____ eyes _____ nose _____ throat _____ skin _____ urinary tract

H. Do you experience any of the following on a chronic basis?
_____ heart burn _____ nausea _____ diarrhea _____ blood in stool _____ mucus in stool

I. Have you experienced in the last year persistent (check all that apply)?

- Change in voice quality _____
- Chronic hoarseness _____
- Difficulty clearing throat _____
- Pain on swallowing _____
- Difficulty swallowing _____
- Bloody nose _____
- Coughing up blood _____
- Abnormal discharge (e.g. mucus, blood, pus) from:
_____ eyes _____ ears _____ nose _____ mouth
- "Pins and needles" sensation in head and neck _____
- Numbness in head and neck _____

J. Have you had a blood transfusion? _____ Yes _____ No

K. Have you had an organ or bone transplantation? _____ Yes _____ No

L. Do you experience chronic dry eyes? _____ Yes _____ No

M. Do you experience chronic dry mouth? _____ Yes _____ No

N. Do you use a mouth rinse (other than commercial mouthwash)? _____ Yes _____ No

O. Do you use chewing gum? _____ Yes _____ No

P. Do you use hard candies? _____ Yes _____ No

Q. Do you have a history of smoking tobacco? _____ Yes _____ No

Please indicate form (e.g. cigarettes, pipe), amount per day, and duration of habit (years)

R. Do you have a history of using smokeless tobacco? _____ Yes _____ No

Please indicate form (e.g. snuff, chewing tobacco), amount per day, and duration of habit (years)

S. Do you have a history of alcoholic beverage consumption? _____ Yes _____ No

Please indicate form (e.g. beer, wine, whiskey), amount per day, and duration of habit (years)

6) Please rate the following:

	Excellent	Good	Fair	Poor		
Vision	_____	_____	_____	_____	Lens-corrected?	___ Y ___ N
Hearing	_____	_____	_____	_____	Hearing aid?	___ Y ___ N
Balance	_____	_____	_____	_____		
Taste	_____	_____	_____	_____		
Smell	_____	_____	_____	_____		

7) Brand of toothpaste: _____

- Whitening/bleaching formula: _____ Yes _____ No
- Tartar control formula: _____ Yes _____ No

8) Brand of mouthwash: _____

- Frequency of use: _____
- Duration of each use: _____