TACOMA
ORAL SURGERY & IMPLANTS

• Peter D. Gauger DDS
• Mark D. Carlson, MS, DDS

PATIENT INFORMATION

PATIENT NAME _____ BIRTHDATE _____ SEX ❑ F ❑ M

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ SOCIAL SECURITY NUMBER _____

PERSON FILLING OUT FORM ❑ SELF ❑ OTHER, RELATIONSHIP TO PT _____

SINGLE ❑
MARRIED ❑
SEPARATED ❑
DIVORCED ❑
WIDOWED ❑

PRIMARY DENTAL INSURANCE

INS. CO. NAME _____

ADDRESS _____

_____

PHONE _____

SUBSCRIBER NAME _____

SOC. SEC. # _____

GROUP # _____ BIRTHDATE _____

EMPLOYER NAME _____

ADDRESS _____

_____

PHONE _____

SECONDARY DENTAL INSURANCE

INS. CO. NAME _____

ADDRESS _____

_____

PHONE _____

SUBSCRIBER NAME _____

SOC. SEC. # _____

GROUP # _____ BIRTHDATE _____

EMPLOYER NAME _____

ADDRESS _____

_____

PHONE _____

PRIMARY MEDICAL INSURANCE

INS. CO. NAME _____

ADDRESS _____

_____

PHONE _____

SUBSCRIBER NAME _____

SOC. SEC. # _____

GROUP # _____ BIRTHDATE _____

EMPLOYER NAME _____

ADDRESS _____

_____

PHONE _____

WORK INFORMATION

EMPLOYER _____

ADDRESS _____

_____

PHONE _____ EXT _____

JOB _____

STUDENT _____

SCHOOL/LOCATION _____

GRADE/YEAR _____

HAS ANY FAMILY MEMBER BEEN
A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS (if not the same as above) _____ PHONE _____

REFERRED BY _____ PHYSICIAN'S NAME _____

PHONE _____ PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP TO PATIENT _____ ADDRESS _____ PHONE _____

INJURY INFORMATION: DATE OF INJURY _____ PLACE OF INJURY _____

JOB RELATED? _____ IF YES, L&I NUMBER _____

BRIEF DESCRIPTION OF ACCIDENT _____

AUTHORIZATION TO RELEASE INFORMATION _____ TODAY'S DATE _____

TACOMA
ORAL SURGERY & IMPLANTS

• Peter D. Gauger DDS
• Mark D. Carlson, MS, DDS

HEALTH QUESTIONNAIRE

NAME _____ DOB _____ AGE _____ SEX ❑ M | ❑ F HEIGHT _____ WEIGHT _____

MEDICAL PHYSICIAN _____ CITY _____ PHONE # _____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL CONDITIONS

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES

_____

_____

_____

_____

_____

SURGERIES/HOSPITALIZATIONS

_____

_____

_____

_____

_____

REASON FOR VISIT _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? LAST VISIT _____ ❑ YES ❑ NO

SPECIFIC CONDITION BEING TREATED _____

ARE YOU IN GOOD HEALTH? _____ ❑ YES ❑ NO

DO YOU EXERCISE? ACTIVITY/FREQUENCY _____ ❑ YES ❑ NO

HAVE YOU BEEN HOSPITALIZED FOR SEVERE ILLNESS? IF YES WHAT _____ ❑ YES ❑ NO

HAVE YOU BEEN TOLD YOU NEED TO TAKE AN ANTIBIOTIC PRIOR TO DENTAL SURGERIES/PROCEDURES? ❑ YES ❑ NO

PERSON FILLING OUT FORM ❑ SELF ❑ OTHER, RELATIONSHIP _____

DOCTOR NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

I CERTIFY THAT THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ PRINT NAME _____ DATE _____

GENERAL HEALTH

	YES	NO
RECENT MAJOR WEIGHT LOSS OR GAIN	❑	❑
TIRED EASY	❑	❑
FEVERS	❑	❑
HAVE CONTAGIOUS DISEASE	❑	❑
HAVE DISEASE THAT LIMITS DAILY ACTIVITIES	❑	❑
RECENT COLD/ILLNESS	❑	❑

ANESTHESIA

	YES	NO
HAVE YOU HAD A GENERAL ANESTHESIA(SEDATION/ASLEEP):	❑	❑
ALLERGIES/BAD REACTIONS TO MEDICATIONS?	❑	❑
DELAYED RECOVERY	❑	❑
NAUSEA/VOMITING	❑	❑
ICU STAY	❑	❑
MALIGNANT HYPERTHERMIA	❑	❑

HEAD, FACE, & NECK

	YES	NO
FACIAL COSMETIC SURGERY (FACELIFT/NOSEJOB/BROW/EYLELID)	❑	❑
BOTOX/INJECTABLE FILLERS (COLLAGEN/RESTYLANE)	❑	❑
RADIATION	❑	❑
EXPOSED BONE/NON HEALING ULCERS	❑	❑
ENLARGED GLANDS/LYMPHNODES	❑	❑
HEADACHES	❑	❑
NUMB AREAS	❑	❑
THYROID SURGERY	❑	❑
TRACHEOSTOMY/EMERGENCY SURGICAL AIRWAYS	❑	❑

OTHER_____

NERVOUS SYSTEM

	YES	NO
STROKE	❑	❑
CONVULSIONS / EPILEPSY / SEIZURES	❑	❑
ANXIETY/DEPRESSION/EMOTIONAL CONDITIONS	❑	❑
PSYCHIATRIC CONDITIONS	❑	❑
HEAD/BRAIN INJURIES	❑	❑
NUMBNESS/TINGLING	❑	❑
FAINTING/BLACKOUT SPELLS	❑	❑
DEGENERATIVE CONDITIONS (MS, ALS)	❑	❑

CURRENTLY TAKING (CIRCLE IF YES):

-BARBITUATES, ANTICONVULSANTS (DILANTIN),

-TRANQUILIZERS (BENZODIAZEPINES), SLEEPING PILLS

OTHER_____

RESPIRATORY

	YES	NO
ASTHMA	❑	❑
COPD / EMPHYSEMA / PERSISTENT COUGH	❑	❑
TUBERCULOSIS / COUGH BLOOD	❑	❑
DIFFICULTY BREATHING LYING DOWN	❑	❑
ALLERGIES / HAY FEVER	❑	❑
HOME OXYGEN	❑	❑

ON MEDICATIONS (CIRCLE IF YES):

-STEROIDS (PREDNISONE, CORTISONE)

-BRONCHODILATORS (AMINOPHYLLINE, THEOPHYLLINE)

-COLD MEDICATIONS (ANTIHISTAMINES, ALLERGY DRUGS)

OTHER_____

DENTAL & ORAL

	YES	NO
PREVIOUS ORAL SURGERY _____		
PREVIOUS ORAL SURGEONS _____		
LOOSE TEETH	❑	❑
GRINDING TEETH	❑	❑
EXPOSED BONE/OSTEONECROSIS/OSTEOMYELITIS	❑	❑
UNHEALING SORES/ULCERS	❑	❑
GROWTHS/BUMPS/MASSES	❑	❑
SALIVARY GLAND PROBLEMS	❑	❑
DIFFICULTY OPENING/CLOSING JAW	❑	❑
TMJ (JAW JOINT) PROBLEMS	❑	❑

OTHER_____

THROAT

	YES	NO
RECENT VOICE CHANGES/HOARSENESS	❑	❑
DIFFICULTY BREATHING	❑	❑
DIFFICULTY SWALLOWING	❑	❑
TONSIL SURGERY	❑	❑
CANCER / TUMORS	❑	❑
SNORING / SLEEP APNEA	❑	❑

EYES

	YES	NO
GLAUCOMA / BLINDNESS	❑	❑
RECENT VISION CHANGES	❑	❑
WEAR CONTACT LENSES	❑	❑

NOSE/SINUS

	YES	NO
CHRONIC SINUS PROBLEMS	❑	❑
FREQUENT NOSE BLEEDS	❑	❑

HEART/BLOOD VESSELS

	YES	NO
HIGH BLOOD PRESSURE	❑	❑
HEART DEFECT AT BIRTH	❑	❑
DAMAGED HEART VALVES, PROLAPSE	❑	❑
ARTIFICIAL HEART VALVES OR GRAFT	❑	❑
PACEMAKER / IMPLANTED DEFIBRILLATOR	❑	❑
RHEUMATIC FEVER/HEART DISEASE/SCARLETT FEVER	❑	❑
ENDOCARDITIS (VALVE INFECTION)	❑	❑
HEART MURMUR	❑	❑
SWOLLEN ANKLES	❑	❑
CHEST PAIN / DISCOMFORT / ANGINA	❑	❑
HEART ATTACK	❑	❑
ARRYTHMIA (ATRIAL FIBRILLATION)		
UNABLE TO CLIMB 2 FLIGHTS OF STAIRS	❑	❑
CURRENTLY TAKING (CIRCLE IF YES):	❑	❑

-CHEST PAIN DRUGS (NITROGLYCERINE)

-ANTIARRYTHMIA DRUGS (DIGITALIS, PROPRANOLOL/ INDERAL, METOPROLOL, AMLODIPINE, NIFEDIPINE)

-ANTICOAGULANTS /BLOOD THINNERS (WARFARIN, PRADAXA, ASPIRIN, PLAVIX, LOVENOX, ENOXAPARIN, HEPARIN)

-DIET PILLS

HEART SURGERY_____

CARDIOLOGIST _____

OTHER_____

KIDNEY / GU

YES NO

KIDNEY DISEASE/RENAL FAILURE ❑ ❑
DIALYSIS / KIDNEY TRANSPLANT ❑ ❑
SEXUALLY TRANSMITTED DISEASES ❑ ❑
OTHER_____

BONE / MUSCLE / JOINT

YES NO

ARTHRITIS / RHEUMATISM ❑ ❑
ARTIFICIAL JOINTS ❑ ❑
OSTEOPOROSIS ❑ ❑
MUSCULAR DYSTROPHY ❑ ❑
MUSCLE WEAKNESS CONDITIONS
(MYASTHENIA GRAVIS) ❑ ❑

EVER TAKEN (CIRCLE IF YES):

-RHEUMATOLOGIC DRUGS: METHOTREXATE, HUMIRA, EMBREL, PREDNISONE,
-BISPHOSPHONATES: BONIVA, FOSAMAX, ACTONEL, ZOMETA, AREDIA, ALENDRONATE, IBANDRONATE, ZOLENDRONATE, RISEDRONATE,
-OTHER ANTI RESORPTIVES: DENOSUMAB: PROLIA, XGEVA

OTHER_____

FEMALE

YES NO

PREGNANT? ❑ ❑
MONTHS? _____
TRYING TO GET PREGNANT ❑ ❑
EXCESSIVE BLEEDING DURING PERIOD ❑ ❑

CURRENTLY TAKING (CIRCLE IF YES):

-BIRTH CONTROL PILLS, HORMONE REPLACEMENT DRUGS

OB GYNECOLOGIST (IF PREGNANT): _____
OTHER_____

SOCIAL HISTORY / PAIN MEDICATIONS

YES NO

SMOKE CIGARETTES ❑ ❑
❑ CURRENT _____ PACK PER DAY
❑ FORMER, QUIT (YEAR) _____
ESTIMATED NUMBER OF YEARS SMOKED _____
CHEW OR OTHER TOBACCO USE ❑ ❑
VAPE / E CIG USE ❑ ❑
MARIJUANA USE ❑ ❑
OTHER DRUG USAGE (CURRENT) _____
OTHER DRUG USAGE (FORMER) _____
QUIT (YEAR) _____
ALCOHOLISM ❑ ❑
BEEN TREATED FOR ADDICTION ❑ ❑
REHAB _____
LAST _____

CURRENT NARCOTIC PAIN MEDS USAGE (CIRCLE IF YES):

-OXYCODONE, HYDROCODONE, OXYCONTIN, CODEINE, HYDROMORPHONE
-METHADONE, BUPRENORPHINE, SUBOXONE, TALWIN NX

PAIN CONDITIONS: _____
SPONSOR/PAIN MANAGER _____
PHONE #_____

GASTROINTESTINAL

YES NO

ACID REFLUX / GERD / ULCERS ❑ ❑
HEPATITIS / CIRRHOSIS ❑ ❑
ANOREXIA NERVOSA/ BULEMIA ❑ ❑
BOWEL DISEASE / CROHNS / ULCERATIVE COLITIS ❑ ❑
OTHER_____

HEMATOLOGIC / BLOOD / IMMUNE

YES NO

KNOWN BLEEDING DISORDER
(VON WILLIBRANDS, HEMOPHILIA) ❑ ❑
BRUISE EASILY, BLEED LONG TIME ❑ ❑
ANEMIA ❑ ❑
HAD BLOOD TRANSFUSION ❑ ❑
SICKLE CELL ANEMIA / TRAIT ❑ ❑
LEUKEMIA / LYMPHOMA / OTHER CANCERS ❑ ❑
CHEMOTHERAPY ❑ ❑
SPLEEN REMOVED ❑ ❑
ORGAN TRANSPLANT ❑ ❑
HIV / AIDS ❑ ❑
HEPATITIS B OR C VIRUS ❑ ❑

CURRENTLY TAKING (CIRCLE IF YES):

-GINKO, GINSENG, GINGER SUPPLEMENTS

OTHER_____

ENDOCRINE

YES NO

DIABETES ❑ ❑
THYROID DISEASE ❑ ❑
LONG TERM STEROID USE ❑ ❑

CURRENTLY TAKING (CIRCLE IF YES):

-DIABETIC MEDICATIONS - INSULIN, METFORMIN, SULFONYLUREAS
-THYROID DRUGS (LEVOTHYROXINE, PROPRANOLOL)
-STEROIDS (PREDNISONE, HYDROCORTISONE, METHYLPREDNISOLONE)

OTHER_____

FAMILY HISTORY

YES NO

MALIGNANT HYPERTHERMIA ❑ ❑
MUSCULAR DYSTROPHY ❑ ❑
LONG QT SYNDROME / SUDDEN DEATH / WPW ❑ ❑
ORAL TUMORS, CYSTS, CANCERS ❑ ❑
BAD REACTIONS TO ANESTHESIA ❑ ❑

OTHER MEDICAL CONDITIONS NOT COVERED ABOVE:

_____

WOULD YOU LIKE TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANYTHING? ❑ ❑

_____

I CERTIFY THAT THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ PRINT NAME _____ DATE _____