AOMSI CONSENT FORM

For A Safer Tomorrow

ORAL &MAXILLOFACIAL SURGERY

HEALTH QUESTIONNAIRE

Patient's Name Age/Sex Date

Please initial on each page after reading. If you have any questions, please ask your doctor BEFORE initialing.

Have you had any of the following Problems? Please tick **YES** or **NO**

GENERAL PROBLEMS:

- Cold , cough ----------Yes \ No
- Fever. ----------Yes \ No
- Sinusitis ----------Yes \ No

  (If Yes, when was the last episode_____)

RESPIRATORY PROBLEMS:

- Nasal obstruction
- Asthma
- Shortness of breath
- Tuberculosis (TB).
- Bronchitis.
- Emphysema
- Lung diseases.

  (If Yes, when was the last episode_____)

HEART PROBLEMS:

- High blood pressure
- Chest pain

Signature ----------

- Heart attack
- Heart murmur
- Pacemakers
- Rheumatic fever
- Irregular heart beat
- Infective endocarditis .
- Angioplasty / Angiogram.
- Bypass surgery.
  (If Yes, mention the details of medication, Procedure date & last visit to the Physician_____
  _____)

CNS PROBLEMS:

- Seizures/ epilepsy
- Stroke
- Paralysis
- Brain tumor
- Muscle weakness
- Neuralgia

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

GIT PROBLEMS:

- Acidity
- Peptic ulcers
- Gall bladder stones
- Colitis
- Appendicitis

- Piles
- Fistula and fissure

Signature ----------

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____)

LIVER AND KIDNEY PROBLEMS:

- Cirrhosis
- Liver failure
- Kidney stones
- Kidney failure
- Prostate obstruction
- Urinary obstruction

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

BLEEDING PROBLEMS:

- Anemia
- Clotting and bleeding time
- Platelet count
- Haemophilia

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

ENDOCRINE PROBLEMS:

- Diabetes

- Thyroid
- Steroids.

Signature ----------

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

PSYCHAITRIC PROBLEMS & COUNCILLING

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

ARTHRITIS:

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

RADIOTHERAPY:

(If Yes, mention the details of Procedure date & last visit to the Physician_____

_____)

PREVIOUS SURGERIES:

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

ACQUIRED DISEASES:

- AIDS
- HEPATITIS – B & C

(If Yes, mention the details of medication, Procedure date & last visit to the Physician_____

_____)

Date of last physical exam: Date of last ECG:

Signature ----------

Are you pregnant: YES/ NO**(If yes specify the trimester_____)**

Are you breast feeding: YES/ NO**(If Yes, since how long_____)**

Have you been under the care of physician during last 2 years?

(If yes, why & when_____)

Have you undergone general anesthesia for an operation?

(If Yes,Operation details &any anesthesia complications noted_____)

Are you taking medicine of any kind: YES/NO

(If Yes, For what & since how long_____)

Do you smoke YES/NO (**If yes, How long _____ how many_____)**

Do you consume alcohol YES/NO **(If yes,How long _____how much_____)**

Do you chew Tobacco/ Areca nutYES/NO **(If yes,How long _____how much_____)**

Are you allergic to any drugs: YES / NO

Pencillin… YES/NO Codeine…YES/NO

Local anesthetic…YES/NO Aspirin….YES/NO

General anesthetic….YES/NO Barbiturates….YES/NO

Any other allergies in specific _____

Do you wear dentures…YES/NO

Do you wear lenses…YES/NO

Any other medicines….YES/NO

(If yes specify the medicine_____)

PATIENT SIGNATURE \ DATE _____

WITNESS SIGNATURE \ DATE _____