

Patients Visiting the Oral Surgery Outpatient Clinic <Medical Questionnaire>

Name:	Age:	Occupation:	Patient ID Number:
Contact number (No. where the hospital can reach you)	Tel:		Nationality:

To have a comfortable and safe oral surgery consultation, it is very important for us to know about your physical condition. Please answer the questions below.

- What is the reason for your visit today? Please write down your symptoms in detail.

(Example: gums are swollen, jaw joints hurt, an ulcer on the tongue, tooth removal, etc.)

.....
When did these symptoms appear?

- Have you ever developed a serious or significant condition? (YES NO)

Please circle the following or fill-in the 'others' section if you have any known diseases.

Asthma ▪ Diabetes ▪ High blood pressure ▪ Heart disease ▪ Liver disease ▪ Kidney disease ▪ Blood disease ▪ Gastroenterological disease ▪ Osteoporosis

Others (.....)

- Are you currently having consultations at a hospital? (YES NO)

St. Luke's International Hospital ▪ Another hospital than St. Luke's Hospital: Dept.:

- Do you currently take any medicine? (YES NO)

Please check the following or write down the names of the medicine.

- Only medicines prescribed at St. Luke's
- I have my "Medication Notebook" with me
- Name(s) of medicine(s).....

- Are you allergic to any medicine? (YES NO)

Please write the name of the medicine and your reaction.....

- Do you have any allergies other than to medicine? (YES NO)

(Example: Latex, metal, food, etc.)

- Have you ever been told you have high blood pressure? (YES NO) B.P. /

- Is it hard for bleeding to stop once you start to bleed? (YES NO)

- Have you ever had a tooth removed? (YES NO)

- Have you ever had dental anesthesia? (YES NO)

- Were there any abnormalities when you had a tooth removed or during anesthesia? (YES NO)

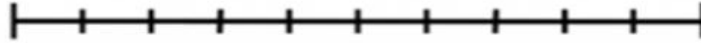
Please describe the abnormality in detail. (Example: Nausea)

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- Please circle the following number that best represents how difficult the past week has been for you.

0 1 2 3 4 5 6 7 8 9 10

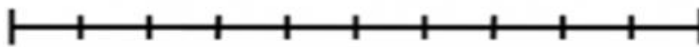


No problems at all

Extremely difficult

To what extent did that difficulty affect your daily life?

0 1 2 3 4 5 6 7 8 9 10



Not at all

Extremely

- Do you smoke? Yes, currently Used to Have never smoked
Number of cigarettes /day

- Do you drink alcohol? NO · YES (Every day · Every week · Sometimes)

- For women Currently Pregnantmonths Unsure Not pregnant
Currently Breastfeeding Not breastfeeding

- At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary.

Do you agree to undergo blood transfusion if necessary? (YES NO)

- Are you scheduled to donate blood for autologous or regular transfusion at this or another hospital? (YES NO)

- Other: Please write down anything you wish to inquire or are concerned about.