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**Diplomate American Board of Oral and Maxillofacial Surgery**

**Oral Pathology**

**Rockefeller Center**

**630 Fifth Avenue, Suite 1868, New York, NY 10111 (212) 969-9133**

**Medical Questionnaire Form**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (Middle) (First)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # (Street) (Apt/Suite) (City) (State) (Zip Code)

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age and Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Closest Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer each question. Check yes or no. If in doubt, leave blank

Are you now under the care of a physician? ( ) Yes ( ) No

If so, what is the condition being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized? ( ) Yes ( ) No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous surgery?

If yes, please explain when and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women) Are you pregnant? If so, give due date ( ) Yes ( ) No Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women) Are you taking birth control pills? ( ) Yes ( ) No

Have you ever taken prescription medication for weight reduction (Diet Pills)? ( ) Yes ( ) No

If “yes” did you take any of the following drugs listed below?

\_\_\_\_Fen-Phen \_\_\_\_Pondimin \_\_\_\_\_Redux

If you have ever taken any of the above drugs, have you had a medical exam to insure your heart valves were not affected? ( ) Yes ( ) No

Do you take Bisphosphonate or have you taken this medication in the past 10 years? ( ) Yes ( ) No

Do you smoke? ( ) Yes ( ) No

If yes, how long and how many packs a day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? ( ) Yes ( ) No

If “yes” what type and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EAR, NOSE AND THROAT

Sinus Problem ( ) Yes ( ) No

NERVOUS SYSTEM

Stroke ( ) Yes ( ) No

Convulsions/Epilepsy ( ) Yes ( ) No

Psychiatric treatment ( ) Yes ( ) No

RESPIRATORY

Tuberculosis ( ) Yes ( ) No

Emphysema ( ) Yes ( ) No

Asthma ( ) Yes ( ) No

Persistent Cough ( ) Yes ( ) No

Snoring ( ) Yes ( ) No

ENDOCRINE

Diabetes ( ) Yes ( ) No

Thyroid Condition ( ) Yes ( ) No

HEART

Rheumatic Fever ( ) Yes ( ) No

Heart Murmur ( ) Yes ( ) No

Chest Pain ( ) Yes ( ) No

Heart Attack ( ) Yes ( ) No

Shortness of Breath ( ) Yes ( ) No

Swelling of Ankles ( ) Yes ( ) No

High Blood Pressure ( ) Yes ( ) No

Congenital Heart disease ( ) Yes ( ) No

Artificial Heart Valve ( ) Yes ( ) No

Pacemaker ( ) Yes ( ) No

Heart Surgery ( ) Yes ( ) No

BONE/MUSCLES

Arthritis/Rheumatism ( ) Yes ( ) No

Artificial Joints ( ) Yes ( ) No

DIGESTIVE SYSTEM

Hepatitis ( ) Yes ( ) No

Ulcers ( ) Yes ( ) No

URINARY

Kidney Disease ( ) Yes ( ) No

Burning during Urination ( ) Yes ( ) No

Bloody Urine ( ) Yes ( ) No

BLOOD

Bruise Easily ( ) Yes ( ) No

Anemia ( ) Yes ( ) No

Blood Transfusion ( ) Yes ( ) No

OTHER

Cancer ( ) Yes ( ) No

AIDS or HIV ( ) Yes ( ) No

Are you allergic or ever experienced any reaction to the following?

Local Anesthetics (e.g. Novocain) ( ) Yes ( ) No

Barbiturate/sedatives/sleeping pills ( ) Yes ( ) No

Penicillin ( ) Yes ( ) No

Aspirin ( ) Yes ( ) No

Codeine ( ) Yes ( ) No

Other Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any of the following?

Antibiotics/ Sulfa Drugs ( ) Yes ( ) No

Blood Thinners ( ) Yes ( ) No

Blood Pressure Medication ( ) Yes ( ) No

Thyroid Medication ( ) Yes ( ) No

Cortisone/Steroids ( ) Yes ( ) No

Antihistamines/Allergy Drugs/Cold Rememdies ( ) Yes ( ) No

Tranquilizers ( ) Yes ( ) No

Insulin/Other Diabetes Drugs ( ) Yes ( ) No

Nitroglycerin ( ) Yes ( ) No

Aspirin ( ) Yes ( ) No

Bisphosphonate, Such as Fasomax, Boniva ( ) Yes ( ) No

Other Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes to any of the above, list name of medication and dosage below:

Is there any disease, condition or problems not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so,

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all the preceding answers are true and correct. If I ever have change in my health or change in my medication, I will inform the doctor at the next appointment.

Signature and Date of Patient, Parent, or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that upon my request, I was provided with a copy of the Columbia University Health Sciences Notice of Privacy Practices.

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Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative If Personal Representative, Personal

 Representative Right to Act

PAYMENT POLICY

This office makes every effort to keep down the cost of our patient’s oral surgical care. The patient can

Help by paying upon completion of each visit. Other arrangements can be made with our office manager

depending upon special circumstances.

This office does not participate with any insurance company; therefore, neither dental/ or medical

insurance are accepted for routine procedures. Please remember that insurance is considered a method

of reimbursing the patient for fees paid at the doctor’s office and is not a substitute for payment.

If the patient would like to contact the Insurance Company to inquire for reimbursement for their visit, it is the patient’s responsibility to fax or mail in the bill given to the patient upon completion of the procedure. Subsequently, if patient needs any help with his/her claim, the staff is available to provide additional assistance. Thank you for your cooperation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patient Signature