

- 17. Diabetes? Thyroid, pituitary, or adrenal gland condition?.....YES NO
- 18. Hepatitis, jaundice, or liver disease?.....YES NO
- 19. Have you ever been told not to donate blood? If YES, why?.....YES NO
- 20. AIDS or tested positive for HIV?.....YES NO
- 21. Arthritis or inflammatory rheumatism?.....YES NO
- 22. Stomach ulcers?.....YES NO
- 23. Kidney trouble?.....YES NO
- 24. Low blood pressure?.....YES NO
- 25. Have you ever had a nervous breakdown or psychotherapy?.....YES NO
- 26. Do you have a history of alcoholism or drug dependence?.....YES NO
- 27. Have you ever taken any "recreational" drugs in the past such as cocaine, crack, marijuana, LSD?..... YES NO
 - a. If yes, what? When?
- 28. Do you have a history of smoking?.....YES NO
 - a. If yes, how much per day? How many years have you smoked? _____
- 29. Do you have a history of drinking alcohol?.....YES NO
 - a. If yes, how much do you drink **per day** averaged over the week? _____
- 30. Do you bleed or bruise easily? Or do you have hemophilia or von Willebrand Disease?.....YES NO
- 31. Do you have any blood disorder, such as anemia or sickle cell anemia?.....YES NO
- 32. Have you ever received a blood transfusion?.....YES NO
- 33. Have you had surgery, x-ray treatment, or chemotherapy for a tumor, cancer, or any other condition?.....YES NO
- 34. Please list all medications you are currently taking _____
- 35. Please list all allergies to medication, latex, or food _____
- 36. Have you or a close relative ever had a bad reaction to any anesthetic drug?.....YES NO
- 37. Have you ever had complications during a previous anesthetic?..... YES NO
- 38. Do you have any disease, condition, or problem not mentioned above?..... YES NO
 - a. If YES, what? _____
- 39. WOMEN:
 - a. Is there any possibility that you are pregnant?.....YES NO
 - b. Are you a nursing mother?.....YES NO

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Jinsoo Kim of any changes in my medical status at the earliest possible time.

Signature of Patient

Date

Reviewed by: Jinsoo Kim, DDS

Date