TIMBERLEA
SERVICES CENTRE

Oral Surgery Patient Intake Form

Demographics

Date (dd/mm/yyyy):_________

Name: (First)_____________________ (M.I) ______ (Last)___________________ Male □ Female □ Non-Binary □

Care Card: _____________________________ Family Physician: ____________________ Fax: _________________

Address: _______________________________ (Apt) _________ City: ____________________________________

Postal Code: _______________________ Cell Phone:_____________________ Home Phone: ________________

Email: _____________________________________ Marital Status: Single □ / Married □ / Other □

Height: __________ Weight: ________ Age: _________ Birthday: (dd/mm/yyyy) __________________________

BMI: _______________ *calculated upon arrival

Emergency Contact

Name (First) ___________________ (Last) ________________________________ Tel: _______________________

Relationship to patient: _____________________________________ City: ________________________________

Same household as patient? Yes □ No □

Employment Information

Full-time □ Part Time □ Student □ Retired □ Other □

Occupation: ___________________________________

Employer/School: ___________________________________ City: _______________________________________

Referral Information

Referred by (Patient, Physician or Dentist): ____

How did you hear about Timberlea Services Centre? ____

Facebook □	Electric Billboard □	Mommy Network □
Instagram □	Street Signage □	Trade Show □
Email □	Radio Ad □	
Movie Theatre Ad □	Word of Mouth □	

Have you been to our dental website https://timberleasc.ca/ ? Yes □ No □

If yes, did you find it helpful? Yes □ No □ / If No please explain: _____________________________________

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Procedure Information

What procedures are you interested in or referred for? (Check all applicable procedures below)

Non-Surgical	Surgical Procedures
□ Botox for TMJ □ Consultation only	□ Wisdom teeth extractions □ Bone Grafting □ Sinus Lift □ Dental Implant □ Biopsy □ Tongue concerns □ Jaw concerns

Please describe why you are interested in the above procedure(s):

____

Have you consulted with other physicians about the above procedure(s) before? Yes □ No □

If yes, please indicate: Dr. (Name): ____________________ City: __________________ Year: ______________

Surgery Scheduling

To help us better understand your individual needs and time preference for your surgery, please provide us with the following:

If you choose to have surgery what month(s) would work best for you? ___________________________

Personal Health Information

Do you have, or have you had, any of the following? Check (√) yes if applicable:

□ Acrylic Allergy
□ AIDS/HIV Positive
□ Amoxicillin Allergy
□ Anaphylaxis
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□Aspirin Allergy
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Clindamycin Allergy
□ Codeine Allergy
□ Cold Sores/Fever Blisters
□ Cortisone Medication Allergy
□ Diabetes
□ Drug Addiction
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/ Dizziness
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Disease
□ Heart Pace Maker
□ Heart Trouble
□ Hemophilia
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Herpes
□ High Blood Pressure
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Latex Allergy
□ Leukemia
□ Liver Disease
□ Local Anesthetics Allergy
□ Low Blood Pressure
□ Metal Allergy
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Penicillin Allergy
□ Radiation Treatments
□ Renal Dialysis
□ Rheumatism
□ Sinus Trouble
□ Stroke
□ Taking Birth Control
□ Thyroid Disease
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Yellow Jaundice

Other not listed:

____

Family History

Do you have a family history of any medical problems?

Please indicate family members:____

Review of Systems

Please answer the following yes or no questions to the best of your ability. Please provide details to conditions you checked "yes"

Anesthesia			
Malignant hyperthermia of life threatening reaction to anesthesia?	Yes ☐	No ☐	Describe:
Blood relative with life threatening reaction to anesthetic?	Yes ☐	No ☐	Describe:
Problems during past procedures involving anesthesia (including dental)?	Yes ☐	No ☐	☐ Difficulty with breathing tube insertion ☐ Persistent nausea/vomiting ☐ Slow awakening after anesthesia ☐ Long lasting confusion and disorientation ☐ Poor reaction to local anesthesia or freezing ☐ Other:____
Problems with swallowing, chewing, or dental issues/disease?	Yes ☐	No ☐	☐ Dentures (Full ☐ or Partial ☐) ☐ Tongue piercing ☐ Missing, loose or capped teeth ☐ Temporary Mandibular Joint (TMJ) Disorder ☐ Difficulty opening mouth or extending neck
Sleep Apnea			
Diagnosis of Sleep Apnea or the use of a CPAP Machine (breathing device)?	Yes ☐	No ☐	☐ Sleep Apnea ☐ Use of CPAP
If you answered NO to the above please complete ->	**STOP BANG Questionnaire** 1. **Do you snore loudly? (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?** Yes ☐ No ☐ 2. **Do you often feel tired, fatigued or sleepy during the daytime (such as falling asleep talking to someone?)** Yes ☐ No ☐ 3. **Has anyone observed you stop breathing or choking/gasping during your sleep?** Yes ☐ No ☐ 4. **Do you have, or are you being treated for High Blood Pressure?** Yes ☐ No ☐ 5. **Is your BMI >35 kg/m2** Yes ☐ No ☐ 6. **Are you older than age 50?** Yes ☐ No ☐ 7. **Neck size large ? (Measured around Adams apple)** **For male, is your shirt collar 17 inches / 43cm or larger?**		

	For female, is your shirt collar 16 inches / 41cm or larger? Yes □ No □ **8. Are you male gender?** Yes □ No □

STOP-BANG SCORE
□ Yes to 0-2 questions = low risk □ Yes to 3-5 questions = intermediate risk □ Yes to >5 questions = high risk

Allergies and Reactions			
Allergy to **medications?**	Yes □	No □	Please explain: ____ ____
Allergic to **latex** (including dental dams, gloves and condoms)?	Yes □	No □	Last reaction: ____ ____
Other allergies or allergic-like reactions?	Yes □	No □	Please list and describe reactions: ____ ____
Respiratory			
Have you been diagnosed with any breathing or respiratory problems?	Yes □	No □	□ Difficulty with breathing at rest □ Mild asthma (no medications) □ Asthma (controlled with medications) □ Chronic asthma (no medication) □ COPD- including emphysema or chronic bronchitis □ Lung Cancer □ Pulmonary Fibrosis □ Cystic fibrosis □ Pneumonia within the last month □ Home Oxygen _____ litres/min □ Other: __________________________________
Function			
Difficulty with exercise/everyday movements?	Yes □	No □	Shortness of breath: □ At rest □ During exercise □ Climbing stairs □ Use of cane or walker □ Use of wheelchair □ Muscular pain □ Joint pain, including arthritic pain □ Other: __________________________________
Cardiovascular			
High blood pressure or take blood pressure medication?	Yes □	No □	□ High blood pressure – not using medication □ High blood pressure- somewhat controlled with medication □ Normal blood pressure- controlled with medication
Heart trouble/issues?	Yes □	No □	□ Heart attack- When: ________________________ □ Chest pain or angina – with exercise □ at rest □ □ Chest pressure □ Congestive heart failure (including fluid in lungs) □ Heart valve problems or murmur □ Irregular heartbeat or palpitations □ Atrial fibrillation □ Pulmonary Hypertension □ Peripheral vascular disease

			□ Hypotension (low blood pressure) □ Blood clot in lungs or legs (including deep vein thrombosis – DVT) □ Other: ____
Implanted heart device (pacemaker or ICD)?	Yes □	No □	□ Implanted Cardioverter Defibrillator □ Pacemaker- last checked (date) _____________________ Are you always dependent on your pacemaker? Yes □ No □
Open heart surgery, heart valve or blood vessel surgery?	Yes □	No □	
Any type of clotting disorder or disease?	Yes □	No □	□ Sickle cell disease or hemochromatosis □ Hemophilia □ Anemia □ Blood clots □ Phlebitis □ Von Willebrand's Disease
Diabetes			
Any Type of Diabetes	Yes □	No □	□ Type 1 □ Type 2 – taking insulin □ Type 2- taking pill medications □ Type 2- not taking medications
Endocrine			
Any type of kidney disease?	Yes □	No □	□ Dialysis □ Kidney stones
Any type of thyroid disease?	Yes □	No □	□ Low thyroid (Hypothyroidism) □ High thyroid (Hyperthyroidism)
Any type of liver disease?	Yes □	No □	□ Cirrhosis Caused by: □ Hepatitis □ Alcohol/Drugs Other: ____
Neurological			
Any type of neurological disorder or impairment?	Yes □	No □	□ Seizures or epilepsy. Date of last seizure: ____ □ Brain tumor, aneurysm, or other vascular lesion of the brain □ Concussion or brain injury □ Dementia or Alzheimer's □ Neurostimulator □ Confusion □ Stroke, Mini-stroke (TIA) □ Full recovery □ Partial recovery
Any type of neuromuscular disorder or impairment?	Yes □	No □	□ Cerebral palsy □ Parkinson's disease □ Multiple sclerosis □ ASL/Lou Gehrig's disease □ Muscular dystrophy □ Myasthenia Gravis □ Paralysis
Any risk of CJD (Creutzfeld-Jacobs Disease, sometimes known as "Mad Cow")?	Yes □	No □	□ Suspected CJD □ Family history of CJD or other prion disease □ Growth hormone or gonadotrophin treatment from human pituitary glands (Year of treatment: ___________) □ Surgery on brain or spinal cord

Musculoskeletal			
Any type of muscular/skeletal disease or injury	Yes ☐	No ☐	☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Osteoporosis ☐ Recent fractures ☐ Joint replacement ☐ Ankylosing spondylitis ☐ Back pain, neck pain or deformity that limits movement Details: ____
Gastrointestinal			
Any type of gastrointestinal issues or disease?	Yes ☐	No ☐	☐ Hiatus hernia ☐ Chronic heart burn or acid reflux ☐ Stomach ulcer ☐ Crohn's disease ☐ Colitis ☐ Irritable Bowel Syndrome (IBS) ☐ Diverticulitis ☐ Other: ____
Mental Health			
Have you been diagnosed with a mental health concern?	Yes ☐	No ☐	☐ Anxiety ☐ Depression ☐ Mood disorder ☐ Currently medicated ☐ Recent admission to hospital ☐ Previous suicide attempts
Infections			
Any type of chronic infections?	Yes ☐	No ☐	☐ HIV ☐ Other STDs (Describe: ___________________________) ☐ Hepatitis ☐ Other: ____
At risk for antibiotic resistant infection?	Yes ☐	No ☐	☐ Confirmed antibiotic resistant organism (ARO) such as MRSA, VRE, or C-difficile? Location: ______________________________ ☐ Has anyone in your household been diagnosed with an ARO such as MRSA/VRE? ☐ Have you received healthcare in a facility outside of Canada within the last 12 months? ☐ Have you been admitted to, or spent more than 12 hours continuous as an inpatient in any healthcare facility in the last 12 months?
Lifestyle, Current Health and Substance Use Screening			
Do you smoke (or did you), consume alcohol, or use recreational drugs?	Yes ☐	No ☐	☐ Current smoker, ________ cigarettes/day ☐ Past smoker _______ years ago ☐ Consume alcohol ______ drinks/week ☐ Recreational drugs (type):____ ____ ☐ Nicotine product use (patch, inhaler, gum) ☐ Vaping

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Pregnant?	Yes ☐	No ☐	How many weeks?_____________________________
Current illness or injury	Yes ☐	No ☐	☐ Cold or flu ☐ Injury _______________________________________ ☐ Infection: __________________________________ ☐ Open wound or abscess ☐ Acute temporary pain (less than 6 weeks) ☐ Mild temporary pain (less than 6 weeks) ☐ Chronic pain (more than 6 weeks) ☐ Other: ______________________________________
Being treated for cancer?	Yes ☐	No ☐	Type ____ ☐ Chemotherapy in the last 90 days ☐ Radiation in the last 90 days ☐ In remission __________ (number in years)
Significant weight loss or weight gain within the last 6 months?	Yes ☐	No ☐	☐ Weight gain ________ (lbs) ☐ Weight loss ________ (lbs) ☐ Weight loss surgery Type: ________________________________ When: _______________________________
Past Surgeries (list below) Check if none ☐			
Procedure:	Facility: _______________________________________ Date: ____		
Procedure:	Facility: _______________________________________ Date: ____		
Procedure:	Facility: _______________________________________ Date: ____		

Medications (including over the counter, vitamins, supplements and herbal remedies) Check if none ☐ *include dose, and how often you take the medication*		
Drug Name:	Dose:	Reason:
Drug Name:	Dose:	Reason:
Drug Name:	Dose:	Reason:
Drug Name:	Dose:	Reason:

Thank you for providing us with this important information!

Form completed by:

Name (printed):

____

Signature: __________________________________ Date: _________________________________