



David E. Rogers, D.D.S.



Patient Questionnaire / Health History

Patient Information	Last Name		First Name		MI	Nickname		DOB	Today's Date	
	Address				City		State		Zip	
	Hm Phone #		Cell # Mom / Dad / Patient			Cell # Mom / Dad / Spouse / Caregiver			Wk #	
	() ()		() () ()			() () ()			() ()	
	Sex M F	Age	WT	HT	Mom's Name / Spouse		Dad's Name / Caregiver		Name & Phone # of Emergency Contact Person () ()	
	Name of Person Responsible for account			Relationship to Patient		Driver's Lic #	Exp Date	Social Security #		DOB
	Address				City		State	Zip	Hm # () ()	Cell # () ()

Medical History	Have you had or have any of the following:		
	Y N Cold / Cough / Fever / Chills	Y N Any Kidney problems:	Y N Suffer from epilepsy?
	Y N Muscle cramps / Spasms	Y N a. Kidney stones	Y N a. Grand mal seizures
	Y N Stroke / Cerebral accident	Y N b. Kidney failure	Y N b. Petit mal seizures
	Y N Paralysis of any kind	Y N c. Kidney dialysis	Last seizure _____
	Y N Numbness of any kind	Y N d. Kidney infections	Duration _____
	Y N Heartburn	Y N e. Urinary tract infections	Frequency _____
	Y N Gastric Reflux	Y N f. Urinary retention	Y N Febrile seizure/When _____
	Y N Hiatal Hernia	Y N g. Pain with urination	Y N Are you pregnant?
	Y N Any problems with your blood:	Y N Sugar Diabetes	Last menstrual cycle _____
	Y N a. Anemia	Y N a. Type I (IDDM)	Y N Problems with you heart:
	Y N b. Leukemia	Y N b. Type II (NIDDM)	Y N a. Heart murmur
	Y N c. Sickle Cell disease / trait	Y N Any back or neck problems	Y N b. Chest pain
	Y N d. Cancer	Y N Do you drink alcohol?	Y N c. Skipped beats
	Y N e. HIV	How much per day? _____	Y N d. Heart attack
Y N f. Malaria	How many years? _____	Y N e. Shortness of breath	
Y N Received any blood transfusions	Y N Latex allergy	Y N f. High blood pressure	
Y N Any family with bleeding problems	Y N Hysterectomy	Y N g. Rheumatic fever/disease	
Y N Any smokeless tobacco	Y N Any central nervous system problems:	Y N h. CABG	
Y N Do you smoke	Y N a. Autism	Y N Problems with your lungs	
Packs / cigs per day _____	Y N b. ADHD	Y N a. Asthma	
# years you have smoked _____	Y N c. Cerebral Palsy	Y N b. Reactive airway disease	
Y N Any Thyroid problems:	Y N d. Mental retardation	Y N c. Emphysema	
Y N a. Hypothyroid	Y N e. Seizure disorder	Y N d. Bronchitis	
Y N b. Hyperthyroid	Y N f. Down's syndrome	Y N Have you used marijuana	
Y N Any Liver problems:	Y N g. Headaches	Y N a. Cocaine	
Y N a. Cirrhosis	Y N h. Migraines	Y N b. Heroin	
Y N b. Hepatitis	Y N i. Depression	Y N c. PCP	
Y N c. Yellow jaundice	Y N j. Manic / depression	Y N d. Amphetamines	
Y N Fibromyalgia	Y N Allergies or intolerances to meds?	Y N Any other recreational drugs	
Y N Do you wear dentures?	Which medicines? _____	_____	
_____	_____	_____	
What medicines are you currently taking?	_____	Y N Have you or any other blood relatives ever have a problem related to a surgery or a general anesthetic? Who?	
_____	Name & number of your Physician?	_____	
_____	_____	Have you had any surgeries? Which ones?	
_____	() _____	_____	
_____	Date of Last physical exam _____	_____	
_____	_____	Any other syndromes not mentioned?	

Dental Office	Name of Dental Office	Appointment Date	Appointment Time	Appointment Length
	_____	_____	_____ am / pm	_____