



# David E. Rogers, D.D.S.



## Patient Questionnaire / Health History

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

|                                       |  |   |                                |
|---------------------------------------|--|---|--------------------------------|
| <b>Medical History</b>                | Have you had or have any of the following: |   |                                |
|                                       | Y N Cold / Cough / Fever / Chills / Covid  | 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 / TIA       | Y N b. Kidney failure                         | Y N b. Petit mal seizures      |
|                                       | Y N Paralysis / Numbness of any kind       | Y N c. Kidney dialysis                        | Last seizure _____             |
|                                       | Y N Anxiety                                | Y N d. Kidney infections                      | Duration/Frequency _____       |
|                                       | Y N Heartburn                              | Y N e. Urinary tract infections               | Y N Febrile seizure/When _____ |
|                                       | Y N Gastric Reflux                         | Y N f. Urinary retention                      | Y N Neuropathy Hands / Feet    |
|                                       | 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 (BS/A1c _____)             | 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. Rheumatic fever / disease              |                                |
| Y N Received any blood transfusions   | Y N Latex allergy                          | Y N f. CABG / Bypass surgery                  |                                |
| Y N Any family with bleeding problems | Y N Hysterectomy                           | Y N Shortness of breath                       |                                |
| Y N Any smokeless tobacco             | Y N Any central nervous system problems:   | Y N High Blood Pressure                       |                                |
| Y N Do you smoke / Vape               | Y N a. Autism                              | Y N Problems with your lungs                  |                                |
| Packs / cigs per day _____            | Y N b. ADHD / ADD                          | Y N a. Asthma                                 |                                |
| # years you have smoked _____         | Y N c. Cerebral Palsy/Mental Retardation   | Y N b. Reactive airway disease                |                                |
| Y N Any Thyroid problems:             | Y N d. Parkinson's                         | 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. Manic / Depression / Bipolar        | Y N a. Cocaine / Heroin / PCP                 |                                |
| Y N a. Cirrhosis                      | Y N Headaches / Migraines                  | Y N b. Amphetamines                           |                                |
| Y N b. Hepatitis                      | Y N High cholesterol                       | Y N Any other recreational drugs              |                                |
| Y N c. Yellow jaundice                | Y N Gag reflex                             | _____   |                                |
| Y N Fibromyalgia                      | Y N Allergies or intolerances to meds?     | Y N Have you or any other blood relatives     |                                |
| Y N Do you wear dentures?             | Which medicines? _____                     | 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?            |                                |

|                      |                       |                  |                  |                    |
|----------------------|-----------------------|------------------|------------------|--------------------|
| <b>Dental Office</b> | Name of Dental Office | Appointment Date | Appointment Time | Appointment Length |
|                      |                       |                  |                  | am / pm            |