Dentist Anesthesiologist

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 # Patient ( )	Cell # Spouse / Caregiver ( )	Wk # ( )		
Sex M F	Age	WT	HT	Spouse	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 / Covid
Y N Muscle cramps / Spasms
Y N Stroke / Cerebral accident / TIA
Y N Paralysis / Numbness of any kind
Y N Anxiety
Y N Heartburn
Y N Gastric Reflux
Y N Hiatal Hernia
Y N Any problems with your blood:
Y N a. Anemia
Y N b. Leukemia
Y N c. Sickle Cell disease / trait
Y N d. Cancer
Y N e. HIV
Y N f. Malaria
Y N Received any blood transfusions
Y N Any family with bleeding problems
Y N Any smokeless tobacco
Y N Do you smoke / Vape
Packs / cigs per day ____________
years you have smoked ________
Y N Any Thyroid problems:
Y N a. Hypothyroid
Y N b. Hyperthyroid
Y N Any Liver problems:
Y N a. Cirrhosis
Y N b. Hepatitis
Y N c. Yellow jaundice
Y N Fibromyalgia
Y N Do you wear dentures?

What medicines are you currently taking?

________________ ________________
________________ ________________
________________ ________________
________________ ________________
________________ ________________
________________ ________________

Y N Any Kidney problems:
Y N a. Kidney stones
Y N b. Kidney failure
Y N c. Kidney dialysis
Y N d. Kidney infections
Y N e. Urinary tract infections
Y N f. Urinary retention
Y N g. Pain with urination
Y N Sugar Diabetes
Y N a. Type I (IDDM)
Y N b. Type II (NIDDM)
Y N Any back or neck problems
Y N Do you drink alcohol?
How much per day? _____________
How many years? ______________
Y N Latex allergy
Y N Hysterectomy
Y N Any central nervous system problems:
Y N a. Autism
Y N b. ADHD / ADD
Y N c. Cerebral Palsy
Y N d. Mental retardation
Y N e. Seizure disorder
Y N f. Down's syndrome
Y N g. Manic / Depression / Bipolar
Y N Headaches / Migraines
Y N High cholesterol

Y N Allergies or intolerances to meds?
Which medicines? _____________
____
____

Name & number of your Physician?
____
( ) ____________________________

Date of Last physical exam _____________

Y N Suffer from epilepsy?
Y N a. Grand mal seizures
Y N b. Petit mal seizures
Last seizure __________________
Duration __________________
Frequency __________________
Y N Febrile seizure/When _____________
Y N Are you pregnant?
Last menstrual cycle ____________
Y N Problems with you heart:
Y N a. Heart murmur
Y N b. Chest pain
Y N c. Skipped beats
Y N d. Heart attack
Y N e. Rheumatic fever / disease
Y N f. CABG / Bypass surgery
Y N Shortness of breath
Y N High Blood Pressure
Y N Problems with your lungs
Y N a. Asthma
Y N b. Reactive airway disease
Y N c. Emphysema
Y N d. Bronchitis
Y N Have you used marijuana
Y N a. Cocaine / Heroin / PCP
Y N b. Amphetamines
Y N Any other recreational drugs
____

Y N Have you or any other blood relatives ever have a problem related to a surgery or a general anesthetic? Who?
____

Have you had any surgeries? Which ones?
____
____

Any other syndromes not mentioned?

Dental Office

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

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