



***PATIENT INFORMATION:*** Today's Date: \_\_\_\_\_ Mountain Dental Anesthesia

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nickname: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

***RESPONSIBLE PARTY:***

Name of Person/Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

***MEDICAL HISTORY:***

Have you ever had any of the following medical problems?

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergy to Latex                             | <input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Palsy         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Medications (Please list below) | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma/Lung Problems                         | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia             |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure                          | <input type="checkbox"/> Y <input type="checkbox"/> N Parkinson's Disease    |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol                             | <input type="checkbox"/> Y <input type="checkbox"/> N Alzheimer's Disease    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmurs/Defects                        | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery                                | <input type="checkbox"/> Y <input type="checkbox"/> N Mastocytosis           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Other Surgery _____                          | <input type="checkbox"/> Y <input type="checkbox"/> N Tracheal Malacia       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Seizure Disorder (Epilepsy)                  | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autism                                       | <input type="checkbox"/> Y <input type="checkbox"/> N Muscular Dystrophy     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                                     | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Anemia     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Down Syndrome                                | <input type="checkbox"/> Y <input type="checkbox"/> N Malignant Hyperthermia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Other Syndromes _____                        | (Patient or Familial History)  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Possibly PREGNANT (Women >10 years old)      |  |

Please discuss any medical problems that you have/had: \_\_\_\_\_

Are you currently under the care of a physician?  Y  N Date of Last Visit: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you followed by a SPECIALIST?  Y  N Please indicate ALL that apply:  Cardiologist  Endocrinologist

Geneticist  Hematologist  Neurologist  Oncologist  Pulmonologist  Other \_\_\_\_\_

Please list ALL current medications: \_\_\_\_\_

Please list ALL allergies (medicine, food, latex, etc.): \_\_\_\_\_

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the **strictest** of confidence and it is my responsibility to inform the doctors of Arizona Dental Anesthesia of any changes in the medical status of this patient at the earliest possible time.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_