Ambulatory Dental Anesthesia of New York

Medical History Questionnaire – Dr. Jason L. Joseph DMD

Please take some time to fill this form and **fax it to 516-453-6005 or Email** ADAofNY@gmail.com. If more space is needed please use the back of this form.

Patient's Name:_____Date of Birth:_____ Age:_____Weight:_____lbs

Address:_____City:_____State:_____Zip_____

Home:_____Cell:_____

Date of Scheduled Treatment:_____ Dentist Name: Dr._____Best Time To Call:_____

Please list any and all medications you are taking (include vitamins, herbals, over the counter meds):_____

Do you have any **ALLERGIES** to any **medications** or **foods (please list)**?_____

1. Are you healthy and overall in good health?_____ Yes No
2. Any major medical issues, surgeries, accidents, or hospitalizations within the last 10 years?_____Yes No

If yes to question 3 please list them:_____

3. Currently are you under the care of a physican?_____ Yes No
4. Do you have/had in the past any of the following heart diseases or complications?_____ Yes No

Circle that apply: Congenital Heart Defect (CHD), Murmurs, Malfunctioning Heart Vales, Pacemaker, Arrhythmias or irregular heart beats, Ventricular or Atrial Septal defects

5. Do you have/had any cardiovascular (heart) complications_____Yes No

Circle that apply: Chest pain or cyanosis (turns blue) upon exertion, Shortness of breath on exertion, High Blood Pressure, Stroke, Recurrent fainting

6. Have you had a recent runny nose, throat, chest cold or flu?_____Yes No

If yes for how long? _____Has it resolved?_____(days/weeks)

Are there persistent symptoms? (i.e.: cough, runny nose?)_____

7. Do you have/had any of the following lung diseases or complications?_____Yes No

Circle that apply: Chronic cough, bronchitis, pneumonia, chronic sinus disease, seasonal allergies, COPD

8. Do you have Asthma?_____Yes No

When was the last attack? _____(Weeks/Months/Years)

How severe and how often do the attacks occur?_____

Do you need daily medication for your asthma? Or as needed?_____ Everyday As Needed

Have steroids been given to you for your asthma?_____Yes No

9. Have you been diagnosed with Sleep Apnea or snore excessively loud at night?_____Yes No
10. Do you have/had any of the following diseases:
    - Liver (hepatitis, Jaundice)?_____Yes No
    - Kidney(kidney stones, ureter or bladder disorders, renal insufficiency or failure)? Yes No
    - Thyroid Disease?_____Yes No
    - Diabetes?_____Yes No Type?_____
    - Stomach Problems (ulcers, stomach acid issues, reflux/GERD, persistent diarrhea, weight loss)? ____Yes No
    - Arthritis (swollen or painful joints or lymph nodes)_____Yes No
    - Muscle Disorders or weakness (low muscle tone, muscular dystrophy)?_____Yes No
    - Seizures, Fainting Spells, Frequent Headaches, or other neurological problems _____Yes No
    - Do you have any of the following? (Circle that apply): Intellectual disabilities, ADHD, Autism, PDD, Mental Health issues
    - Cancer, STD's, HIV, AIDS_____Yes No
11. Do you bruise easily, or have you ever been diagnosed with a bleeding disorder?_____Yes No
12. Have you been diagnosed with a blood disorder like sickle cell anemia or trait?_____Yes No
13. Has any blood relative of yours, ever had a bad or unusual reaction to anesthesia?_____Yes No
14. If there is anything not listed above that you have or had medically? If yes, please explain:_____

_____.

I understand that withholding any information about my child's health could seriously jeopardize his/her safety. I have carefully reviewed the above medical health history carefully and answered all the questions truthfully and best to my knowledge. I also hereby give permission to the staff of Ambulatory Dental Anesthesia to discuss my child's medical health with other professionals involved with his/her care.

Sign Here:_____Print Name:_____Date:_____/_____/_____