NORTH PENN DENTAL ARTS
Stanley J. Heleniak, D.M.D.
Dentist Anesthesiologist
Diplomate, American Dental Board of Anesthesiology
Fellow, American Dental Society of Anesthesiology

PATIENT QUESTIONNAIRE

Name: _____ Date: _____
Physician: _____ Date of last exam: _____

Age: _____ Height: _____ Weight: _____ Language: English or _____

Latex Sensitivity: YES NO
(Have you ever reacted after exposure to Band-Aids, tape, bandages, elastic, spandex, avocados, bananas, tropical fruit, kiwi, rubber products, surgical gloves, balloons?)
Allergies:

_____
_____
_____

Previous Surgeries:

_____
_____
_____

Previous Hospitalizations:

_____
_____

Medical History Review:

System	No	Comments
Central Nervous System/Skeletal ☐ Stroke ☐ Seizure Back/Neck Problems ☐ Arthritis ☐ Other		
Cardiovascular ☐ Hypertension ☐ Angina ☐ Heart Attack ☐ CHF ☐ Heart Murmur ☐ Pacemaker ☐ AICD ☐ Other		
Respiratory ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ Recent cold/flu ☐ Other		
Gastrointestinal ☐ PUD ☐ Hiatal Hernia/Reflux ☐ Other		
Hematologic ☐ Anemia ☐ Bleeding Tendency ☐ Other		
Miscellaneous ☐ Diabetes ☐ Liver Disease ☐ Kidney Disease ☐ Pregnant ☐ Glaucoma ☐ Other		
Psycho/Social ☐ Alcohol- How much: _____ ☐ Smoker- How much: _____ ☐ Street Drugs- Specify: _____		
In the past six weeks have you been exposed to a communicable disease?		
Have you or any of your family members had any problems with anesthesia?		
Do you have an advanced directive?		
Do you wear a hearing aid? Yes or No Do you wear dentures? Yes or No Any caps or loose teeth? Yes or No		

Assessment Information Obtained from: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____