



Medical Questionnaire

Patient Name: _____ DOB: ____/____/____ Age: ____ Weight: ____ lb

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ ☐ Male ☐ Female ☐ _____

Date of Treatment: ____/____/____ Dentist/Surgeon's Name: _____

Have you had a cold, cough, or fever in the last two weeks? ☐ Yes ☐ No Explain _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No Explain _____

Have you or any relatives had complications with anesthesia? ☐ Yes ☐ No Explain _____

Have you taken any illegal substances or recreational drugs? ☐ Yes ☐ No Explain _____

Do you take any prescription or over-the-counter medications? ☐ Yes ☐ No Explain _____

Do you have Asthma or other respiratory problems? ☐ Yes ☐ No Explain _____

Do you use tobacco or are you exposed to second-hand smoke? ☐ Yes ☐ No Explain _____

Do you have an Advanced Directive? ☐ Yes ☐ No Explain _____

Do you have any allergies? Please list and explain reaction. _____

Are you currently under the care of a physician? ☐ Yes ☐ No _____

Do you have, or previously had, any of the following? If yes to any, please explain in comments.

	Y	N		Y	N		Y	N
AIDS/HIV Positive	☐	☐	Developmental Delay	☐	☐	Large Tonsils	☐	☐
Acid Reflux/Stomach Problems	☐	☐	Diabetes/Hypoglycemia	☐	☐	Liver Problems	☐	☐
Anaphylactic Reaction	☐	☐	Disabilities or Restrictions	☐	☐	Loose/Cracked/Chipped Teeth	☐	☐
Bleeds or Bruises Easily	☐	☐	Eczema/Rash/Hives	☐	☐	Lung Disease	☐	☐
Bone/Joint Problems	☐	☐	Glasses/Contact Lenses	☐	☐	Neurologic: Seizures/Migraines	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐	Premature Birth	☐	☐
Chest Pain/Heart Problems	☐	☐	Hepatitis A, B, or C	☐	☐	Psychiatric Issues/Excessive Fears	☐	☐
Chromosomal Abnormality	☐	☐	High Blood Pressure	☐	☐	Snoring/Sleep Apnea	☐	☐
Cold Sores/Fever Blisters	☐	☐	High Cholesterol	☐	☐	Thyroid Disease	☐	☐
Dentures/Dental Appliances	☐	☐	Kidney Problems	☐	☐	Tuberculosis	☐	☐

Do you have, or previously had, a serious illness not listed above? ☐ Yes ☐ No _____

Comments: _____

I understand that withholding information regarding my medical history or health status may compromise my safety. I certify that I have carefully reviewed this form and answered all questions truthfully and to the best of my knowledge. I authorize Midwest Surgery Center Kansas City to communicate with and disclose relevant medical information to other healthcare professionals involved in my case.

It is my responsibility to inform the center if there are any changes in health status.

Signature of Patient, Parent, or Guardian _____

Relationship to Patient: _____ Date: _____