RCSC Form#4

SWVTC Regional Community Support Center (RCSC)
OUTPATIENT
Medical History Questionnaire

Name: _____ Age:_____ Sex: _____ Date: _____

Height: _____ Weight: _____ BP: _____

Reason for Current Visit: _____

Current Diagnosis: _____

_____

Community Physician: _____ Patient ever see a dentist before? If so who/when.

Name Phone # _____

ALLERGIES/DRUG REACTIONS (Including food & latex)	
Substance:	**Type of Reaction**

CURRENT MEDICATIONS (Incl. over the counter meds & herbal meds)	
Drug/Dosage	**Last Dose**

PREVIOUS SEDATIONS: (if available)		
Date:	**Procedure:**	**Medication Used:**

HAVE YOU EVER HAD, OR DO YOU HAVE ANY OF THE FOLLOWING:			
LUNG DISEASE	**YES**	**NO**	**EXPLAIN**
Asthma			
COPD			
History of Pneumonia			
Other			
HEART DISEASE	**YES**	**NO**	**EXPLAIN**
Murmur			
High Blood Pressure			
Coronary Artery Disease			
Other			
Bleeding Disorders			
Neurological Conditions			
History of Seizures			
Other			
Gastrointestinal			
Kidney Diseases			
Endocrine			
Diabetes			
Prosthetic devices			
Previous Surgeries			

Any Previous Adverse Reaction to Sedation: (explain)

_____

_____

Completed by: _____ Date: _____

Name (Relationship to Patient)