Confidential Medical Information for the Office of Dr. Paul D. VanderKelen and Dr. Adam Pasono

Patient Name______________________________________ Birth Date__________________________________

Name of Physician/Medical Dr.____

Please list any In-patient Hospitalizations ____
____

Please list any reasons for which you are currently being treated by a physician_________________________
____

Please list any allergies--including pets, drugs and objects____
____

Please list any medications or pills you are currently taking____
____

Have you or any family member had Diabetes? Yes___ No___ Who?_________________________________

Do you have or have you had any of the following?

Condition	Yes	No	Condition	Yes	No
Asthma	Yes ___	No ___	Heart Murmur/Rheumatic Fever	Yes ___	No ___
Tuberculosis	Yes ___	No ___	Artificial Joint Replacement	Yes ___	No ___
High/Low Blood Pressure	Yes ___	No ___	Blood Transfusions	Yes ___	No ___
Fainting Spells/Nervous Disorders	Yes ___	No ___	Epilepsy/Seizures	Yes ___	No ___
Kidney/Liver Disease	Yes ___	No ___	Hepatitis/Jaundice	Yes ___	No ___
Arthritis	Yes ___	No ___	Venereal Disease/AIDS	Yes ___	No ___
Alcohol Abuse	Yes ___	No ___	Narcotic Use	Yes ___	No ___

Please provide approximate date for any “Yes” answers above._______________________________________
____

Radiation therapy to Head or Neck for tumor? If so where?____

Any form of Tumor or Malignant growth? If so, where?____

Have you ever had heart problems or surgery? Yes___ No___ If so, please provide details.______________
____

Do you have pain in your chest upon exertion? Yes___ No___

Do your ankles swell often? Yes___ No___ Do you wear a Pacemaker? Yes___ No___

Have you had abnormal bleeding from a cut or extraction? Yes___ No___

Female: Are you pregnant at the present time? Yes___ No___ If so, Due Date:______________________

In order to treat your main concern, for what reason have you made this appointment with our office? Are you experiencing any specific dental problem(s) that you think needs immediate attention?___________________
____
____
____

I attest that the above statements are true. **Today’s Date**____

Patient’s Signature____