SWIATOWICZ
DENTAL ASSOCIATES

Andrew Swiatowicz
1211 Milltown Road, Wilmington, DE 19808
(P) 302-239-8230 (F) 302-476-8188
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PATIENT MEDICAL HISTORY*

Patient's Name: | Date of Birth: | Today's Date:

Address: | City, State, Zip:

Group Home/Facility Phone: | House Manager Cell Phone: | Case Manager Phone:

Email Address:

Legal Guardian's Name: | Cell Phone Number: | Relationship to Patient:

Physician Name/Name of Medical Practice: | Phone Number: | Fax Number:

Pharmacy Name: | FULL Address: DO NOT just write a town or road name | Phone Number:

Patient's Sex:
☐Male ☐Female

Females Only:
☐Y ☐N Birth Control
☐Y ☐N Pregnant, How many weeks: ___
☐Y ☐N Nursing

Tobacco Smoking, Vaping or Chewing Habit?
☐Y ☐N

Height: _____
Weight: _____

Is patient confined to wheelchair?
☐Y ☐N ☐As Needed/Can Transfer

Y	N	Condition
☐	☐	ADD/ADHD
☐	☐	AIDS/HIV Positive
☐	☐	Abnormal Breathing
☐	☐	Anemia
☐	☐	Arthritis, Specify: _____
☐	☐	Artificial Heart Valve, Date: _____
☐	☐	Asthma
☐	☐	Autism
☐	☐	Back Problems
☐	☐	Cancer, Specify: _____
☐	☐	Cerebral Palsy
☐	☐	Chemical Dependency
☐	☐	Circulatory Problems
☐	☐	Clinical Depression
☐	☐	Congenital Heart Defect
☐	☐	Diabetes, Specify: _____
☐	☐	Difficulty Breathing
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches

Y	N	Condition
☐	☐	Glaucoma
☐	☐	Hearing Loss
☐	☐	Heart Attack
☐	☐	Heart Surgery, Specify: _____
☐	☐	Hemophilia
☐	☐	Hepatitis, Specify: _____
☐	☐	High Blood Pressure
☐	☐	High Cholesterol/Triglycerides
☐	☐	Intellectual Disability
☐	☐	Joint Replacement, Specify: _____
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Lyme Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Multiple Sclerosis
☐	☐	Pace Maker
☐	☐	Persistent Cough
☐	☐	Psychiatric Problems, Specify: _____
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever

Y	N	Condition
☐	☐	Seasonal Allergies
☐	☐	Seizures, Date:_____
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other: _____
_____

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Is there any other disease, condition, disorder or problem, not listed on page one? ☐N ☐Y, If yes please describe below

Medications: DO NOT submit MAR or other forms. Do not PRN medications. Do not write dosages for frequencies.

☐ None, this patient takes no medication

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Notes:

_____
_____
_____
_____

Signature of Patient/ Legal Guardian/Medical Care Giver: _____