Today's Date: _____

Patient Label
For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

ADULT GENERAL HEALTH QUESTIONNAIRE

Thank you for choosing Sycuan Medical Dental Center as your healthcare provider. Please take the time to answer the following questionnaire for you so we may better serve your healthcare needs.

Patient Name: _____ Date of Birth: _____

ALLERGY

Do you have any allergies to medications, food, environment, etc.? □ Yes □ No
If yes, please list the name of the medication, food, or environmental element that you are allergic to, then add your reaction to each of them.

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

5442 SYCUAN ROAD, EL CAJON, CA 92019
ADMIN OFFICE FAX (619) 445-9764 • DENTAL FAX (619) 445-5419 • MEDICAL FAX (619) 445-0988

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MEDICATION LIST

Please list all the medications you are currently taking.

Medications you take	Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

If you have additional medication, please continue on the back of this page.

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SOCIAL HISTORY

Please provide honest answers to the questions below:			
Cigarette Use:	□ Yes	□ No	Packs per day:
Vaping Use:	□ Yes	□ No	Cartridges per day:
Other Tobacco Use:	□ Yes	□ No	Type:
Alcohol Use:	□ Yes	□ No	Drinks per day:
Recreational Use:	□ Yes	□ No	Type:
Do you exercise regularly?	□ Yes	□ No	Exercise type:
Exposure to domestic violence:	□ Yes	□ No	
Regular seatbelt use:	□ Yes	□ No	

Please provide honest answers to the questions below:		
1. Have you ever felt the need to cut down on your drinking?	□ Yes	□ No
2. Have people annoyed you by criticizing your drinking?	□ Yes	□ No
3. Have you ever felt bad or guilty about your drinking?	□ Yes	□ No
4. Have you ever needed a drink first thing in the morning to steady your nerves or get rid of a hangover?	□ Yes	□ No
Tolerance: How many drinks does it take you to get high? _____		

HEALTH HISTORY

Please provide the most current dates for the following dates for the following tests. ***If unknown****, please write* ***N/A****.*	
TB Skin Test:	Result of TB Skin Test:
Chest X-RAY:	EKG:
Pneumonia Vaccine:	Dental Exam:
Hepatitis Vaccine:	Eye Exam:
Flu Vaccine:	Cholesterol Test:

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Date and Type of Hospitalizations/Surgeries:

_____

_____

_____

_____

*Please provide an honest answer and check the box if **you or any family member** have had the following conditions:*

Alcohol Abuse	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Cardio/Respiratory	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Glaucoma	□ Yes	□ No	Diabetes	□ Yes	□ No
Kidney Disease	□ Yes	□ No	Arthritis	□ Yes	□ No
Transfusions	□ Yes	□ No	Epilepsy	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Liver Disease	□ Yes	□ No
Cancer	□ Yes	□ No	Other:		

Mother Living: □ Yes, Age _____ □ No, Age deceased _____

Father Living: □ Yes, Age _____ □ No, Age deceased _____

*Please provide an honest answer and check the box if **you** have any of the following symptoms.*

GENERAL			***NEUROLOGICAL***		
Weight gain/loss	□ Yes	□ No	Convulsions	□ Yes	□ No
Recurrent fever	□ Yes	□ No	Fainting spells	□ Yes	□ No
Swollen glands	□ Yes	□ No	Numbness, tingling	□ Yes	□ No
Headaches/Fatigue	□ Yes	□ No	Paralysis	□ Yes	□ No
Diet concerns	□ Yes	□ No	Shakes, tremors	□ Yes	□ No
CARDIO/RESPIRATORY			***ENDOCRINE/METABOLISM***		
Bringing up sputum, blood	□ Yes	□ No	Hormonal problems	□ Yes	□ No
Difficulty breathing	□ Yes	□ No	Goiter	□ Yes	□ No
Wheezing, Asthma	□ Yes	□ No	Thyroid problems	□ Yes	□ No
Frequent cough	□ Yes	□ No	***SKIN***		
Pain/Pressure in the chest	□ Yes	□ No	Rashes, eczema	□ Yes	□ No
Previous heart trouble	□ Yes	□ No	Itching	□ Yes	□ No
Murmurs	□ Yes	□ No	Bruising	□ Yes	□ No
Contact with tuberculosis	□ Yes	□ No	Hives	□ Yes	□ No
Swelling of feet or ankles	□ Yes	□ No	Any changes to warts/moles/lumps	□ Yes	□ No
High blood pressure	□ Yes	□ No	***MUSCULOSKELETAL***		
Varicose veins	□ Yes	□ No	Muscle pain	□ Yes	□ No
Palpitations	□ Yes	□ No	Joint pain	□ Yes	□ No
Irregular heartbeat	□ Yes	□ No	Back pain	□ Yes	□ No

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EYES			***EARS***		
Changes in vision	□ Yes	□ No	Change in hearing	□ Yes	□ No
NOSE			Infection	□ Yes	□ No
Frequent bleeding	□ Yes	□ No	Pain	□ Yes	□ No
Sinus trouble	□ Yes	□ No	***KIDNEY/UROLOGICAL***		
THROAT/ORAL			Frequent urination	□ Yes	□ No
Hoarseness	□ Yes	□ No	Difficult urination	□ Yes	□ No
Difficulty swallowing	□ Yes	□ No	Burning in urine	□ Yes	□ No
Frequent sore throat	□ Yes	□ No	Blood in urine	□ Yes	□ No
Dental problems	□ Yes	□ No	Discharge/sores on genitals	□ Yes	□ No
TMJ	□ Yes	□ No	Kidney stones	□ Yes	□ No
GI/LIVER			***BLOOD/LYMPH***		
Jaundice	□ Yes	□ No	Bleeding	□ Yes	□ No
Hernia	□ Yes	□ No	Anemia	□ Yes	□ No
Nausea or vomiting	□ Yes	□ No	Swollen lymph nodes	□ Yes	□ No
Change in bowel habits	□ Yes	□ No	***BREAST***		
Black/bloody stool	□ Yes	□ No	Lumps	□ Yes	□ No
Diarrhea	□ Yes	□ No	Discharge	□ Yes	□ No
Constipation, hemorrhoid	□ Yes	□ No	***PSYCHOLOGICAL***		
Indigestion, heartburn	□ Yes	□ No	Depression	□ Yes	□ No
Ulcers	□ Yes	□ No	Anxiety/nervousness	□ Yes	□ No

Other symptoms you wish to discuss:

_____

_____

_____

FOR WOMEN ONLY:

Please provide the most current dates for the following tests. ***If unknown****, please write* ***N/A****.*
Pap Smear:
Breast Exam:
Date of Onset Last Period:
of Days in Cycle:
History of Abnormal Pap:
Mammogram:
Length of Period:
Type of Birth Control Used:
of Pregnancies: _____ # of Miscarriage: _____ # of Living Children: _____