

Patient Medical History

Name: _____ Date of Birth: _____

Physician: _____ Office Phone: _____

Approximate date of last physical examination: _____

Please Circle

- | | | |
|--|-----|----|
| 1. Are you under any medical treatment now?..... | Yes | No |
| 2. Have you had any major operations? If so what..... | Yes | No |
| 3. Have you had a serious accident involving head injuries?..... | Yes | No |
| 4. Have you had any adverse response to any drugs including penicillin?..... | Yes | No |
| 5. Has a physician ever informed you that you had: | | |
| A Heart Ailment?..... | Yes | No |
| High Blood Pressure?..... | Yes | No |
| Low Blood Pressure?..... | Yes | No |
| Respiratory Disease?..... | Yes | No |
| Diabetes?..... | Yes | No |
| Rheumatic Fever?..... | Yes | No |
| Rheumatism or Arthritis?..... | Yes | No |
| Tumors or Growths?..... | Yes | No |
| Any Blood Disease?..... | Yes | No |
| Any Liver Disease?..... | Yes | No |
| Any Kidney Disease?..... | Yes | No |
| Any Stomach or Intestinal Disease?..... | Yes | No |
| AIDS?..... | Yes | No |
| Hepatitis?..... | Yes | No |
| Epilepsy or other Neurological Disease?..... | Yes | No |
| Cancer?..... | Yes | No |
| 6. Are you taking any kind of drugs or medications including non-prescription?..... | Yes | No |
| 7. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?..... | Yes | No |
| 8. Are you in general good health at this time?..... | Yes | No |
| 9. Have any wounds healed slowly or presented other complications? (excessive bleeding)..... | Yes | No |
| 10. Do you have a history of fainting?..... | Yes | No |
| 11. Have you found yourself short of breath after climbing 2 flights of stairs?..... | Yes | No |
| 12. Have you ever had a reaction to the following?: | | |
| Sulfa drugs..... | Yes | No |
| Barbiturates, sedatives or sleeping pills..... | Yes | No |
| Codeine or other narcotics..... | Yes | No |
| Aspirin..... | Yes | No |

13. When was your last full mouth or bite-wing x-rays taken? _____ Where? _____

14. Chief Dental Complaint:

Women

- | | | |
|--|-----|----|
| 15. Are you Pregnant or nursing at this time?..... | Yes | No |
| 16. Are you taking oral forms of birth control?..... | Yes | No |

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold Dr. Dantini, or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/parent/guardian

Signature of Dentist

Date