Medical History

PETITTO

FAMILY DENTAL

Medical History

Physician ________________ Office Phone___________ Date of Last Exam_________

Are you under medical treatment now? ❑ Yes ❑ No

If so, What?

Have you been hospitalized in the last 2 years? ❑ Yes ❑ No

If so, What?

Are you currently taking any medications? ❑ Yes ❑ No

If so, Which ones?

Have you lost or gained more than 10 pounds in the last year? ❑ Yes ❑ No

Do you use more than 2 pillows to sleep? ❑ Yes ❑ No

Do you ever wake up from sleep short of breath? ❑ Yes ❑ No

Have you ever had excessive bleeding requiring special treatment? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

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Bisphosphonates

Have you ever taken Bisphosphonate medications such as Alendronate (Fosamax), or Boniva for osteoporosis or Padget's Disease? ❑ Yes ❑ No

Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ❑ Yes ❑ No

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Allergies

Are you allergic to or have you had any reactions to the following?

Local anesthetics	❑Yes	❑No	Aspirin	❑Yes	❑No
Penicillin or any other antibiotics	❑Yes	❑No	Metals	❑Yes	❑No
Latex (rubber)	❑Yes	❑No	Iodine	❑Yes	❑No
Sulpha	❑Yes	❑No	Other________________________		

Women

Are you pregnant or think you could be pregnant?	❑Yes _____	Months	❑No
Nursing	❑Yes	❑No	
Do you use birth control prescriptions?	❑Yes	❑No	

Do you have or have had any of the following?

❑ Heart Valve Prolapse	❑ High Blood Pressure	❑ Rheumatism
❑ Heart Failure	❑ Anemia	❑ Arthritis
❑ Heart Attack	❑ Asthma	❑ Pain in Joints
❑ Angina Pectoris (chest pain)	❑ Emphysema	❑ Radiation therapy
❑ Heart Disease	❑ Shortness of Breath	❑ Cancer or Tumor
❑ Congenital Heart Lesions	❑ Hay Fever	❑ Chemotherapy
❑ Scarlet Fever	❑ Allergies or Hives	❑ Thyroid Disease
❑ Artificial Heart Valve	❑ Fainting or Dizzy Spells	❑ Glaucoma
❑ Heart Pacemaker	❑ Epilepsy or Seizures	❑ AIDS or HIV
❑ Heart Surgery	❑ Nervousness	❑ Liver Disease
❑ Any Form of Eating Disorder	❑ Psychiatric Treatment	❑ Ulcers
❑ Kidney Trouble	❑ Genital Herpes	❑ Hepatitis
❑ Diabetes	❑ Heart Murmur	❑ Drug Addiction
❑ Cold Sores or Fever Blisters	❑ Bruise Easily	❑ Alcoholism
❑ Stroke	❑ Blood Transfusion	❑ Tuberculosis
❑ Sickle Cell Disease	❑ Hemophilia	❑ Leukemia
❑ Recreational Drug Use	❑ Swollen Ankles	❑ Joint Replacement
❑ Rheumatic Fever	❑ Heart Murmur	❑

Do you have any disease, conditions, or problem not listed above? If so, please list: ____

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Dental History

Date of last dental visit__________________ Date of last dental cleaning____________________
Date of dental x rays____________________ Previous dentist's name_______________________
How often do you brush your teeth?_______________ How often do you floss? _____________
Are you extremely fearful of the dentist? ❑ Yes ❑ No
Are you happy with the appearance of your smile? ❑ Yes ❑ No
Is there anything about your smile that you would like to change? ❑ Yes ❑ No
If yes, Please Explain:

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Please mark "yes" or "no" to indicate if you have any of the following:

	Yes	No		Yes	No
Bad breath	❑	❑	Fingernail biting	❑	❑
Bleeding gums	❑	❑	Food collection between teeth	❑	❑
Blisters on lips or mouth	❑	❑	Grinding teeth	❑	❑
Burning sensation on tongue	❑	❑	Gums swollen or tender	❑	❑
Chew on one side of mouth	❑	❑	Jaw pain or tiredness	❑	❑
Cigarette, pipe, or cigar smoking	❑	❑	Lip or cheek biting	❑	❑
Clicking or popping jaw	❑	❑	Loose teeth or broken fillings	❑	❑
Dry mouth	❑	❑	Orthodontic treatment	❑	❑
Pain around ear	❑	❑	Periodontal treatment	❑	❑
Sensitivity to cold	❑	❑	Sensitivity to heat	❑	❑
Sensitivity to sweets	❑	❑	Sensitivity to biting	❑	❑

Authorization

I certify that the above information is accurate to the best of my knowledge, and I agree to be treated by Dr. Petitto, his associates and the whole Petitto Family Dental staff. I further understand that payment is due at the time of service, and should it become necessary, any attorney fees, court costs, and collection fees become my responsibility and will be added to my account

I certify that I, and/or my dependent(s), have insurance coverage as described about and assign directly to Petitto Family Dental, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I have read a copy of this office's privacy practices, made available upon request.

Print Name_______________________________________ Date ___/___/___

Signature ____