ANTHONY DINAPOLI DDS, LLC

Patient's Name: _____ Date of Birth: _____

MEDICAL HISTORY

Do you have a personal physician? ☐Yes ☐No
Physician's Name: _____
Address: _____
Phone: _(___)_____ Date of last visit:_____
Your current physical health is: ☐Good ☐Fair ☐Poor
Are you currently under the care of a physician? ☐Yes ☐No
Please explain:_____
Do you smoke or use tobacco in any form? ☐Yes ☐No
Have you had any metal rods, pins or implants? ☐Yes ☐No
Are you taking any medications? ☐Yes ☐No
Please list all of your medications and herbal supplements:

_____
_____
_____
_____

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Herpes/Fever Blisters
Y N	Alcohol/Drug Use	Y N	High Blood Pressure
Y N	Anemia	Y N	HIV or AIDS
Y N	Arthritis	Y N	Hospitalized (for any reason)
Y N	Artificial Bones/Joints/Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusions	Y N	Low Blood Pressure
Y N	Cancer/Chemotheraphy	Y N	Osteoperosis
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease/Trait
Y N	Frequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack/Surgery	Y N	Tuberculosis
Y N	Heart Murmur	Y N	Tumors or Growths
Y N	Hemophilia	Y N	Ulcer/Stomach Disease
Y N	Hepatitis/Yellow Jaundice	Y N	Venereal Disease/STD

Please list any serious medical conditions that you have ever had:

_____
_____

For Women:
Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Why have you come to the dentist today? _____
_____

Your current dental health is: ☐Good ☐Fair ☐Poor
Do you require antibiotics before dental treatment? ☐Yes ☐No
Are you currently in pain? ☐Yes ☐No
Have you ever had a serious/difficult problem with any previous dental work? ☐Yes ☐No
Have you ever had gum disease? ☐Yes ☐No
Do you now or have you ever experienced pain/discomfort in you jaw joint (TMJ/TMD)? ☐Yes ☐No
Any unfavorable dental experiences? ☐Yes ☐No
Are you happy with the color of your teeth? ☐Yes ☐No
Do you like your smile? ☐Yes ☐No
Do your gums bleed? ☐Yes ☐No
How many times do you: floss/week? _____ brush/day? _____
Are your teeth sensitvie to heat, cold or anything else? _____
Have you lost any teeth? ☐Yes ☐No
If so, why? _____
_____

Are you allergic to any of the following:

Y N	Aspirin	Y N	Penicilin
Y N	Tetracycline	Y N	Epinephrine
Y N	Dental Anesthetics	Y N	Jewelry/Metals
Y N	Latex	Y N	Codine
Y N	Other		

Please list any other drugs/materials that you are allergic to:

_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Patient's Signature Date

I verbally reviewed the medical/dental information above with patient herein.

Doctor's Initials:_____ Date: _____