Patient Medical History

DDS
DANTINI DENTAL OF STAMFORD
the art of your smile
www.Dentistdds.com 203-322-5397
12 Camp Avenue, Stamford, CT 06840

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**