

**JOSEPH P SANFELIPPO DDS, SC
FAMILY DENTISTRY**

MEDICAL HISTORY/INFORMATION

Patient Name: _____ Birthdate ___/___/___

Describe your general health: () Excellent () Good () Fair () Poor
Are you currently under a physicians care? () Yes () No

Reason: _____

Dr. _____ Phone # _____ Last physical _____

What medications are you taking? _____

ARE YOUR TEETH SENSITIVE TO:

Heat?	Yes / No	Biting pressure?	Yes / No
Cold?	Yes / No	Do your gums bleed	
Sweets?	Yes / No	when brushing	Yes / No

Have you had a reaction to local anesthetic? () Yes () No
Do you have a history of alcohol abuse or narcotic use? () Yes () No
Do you smoke? () Yes () No
Are you pregnant? () Yes () No
Are you taking oral contraceptives? () Yes () No

Do you have or ever had: (Please mark if any applies to you)

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Heart trouble/ Heart murmur | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer/ Malignant tumor | |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Radiation therapy | |
| <input type="checkbox"/> Lung/ Breathing disorders | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Hepatitis A B C / Liver disease | <input type="checkbox"/> Thyroid disease | |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Premedication for dental visit | |
| <input type="checkbox"/> Contact with AIDS virus | <input type="checkbox"/> Artificial joints or valves | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Other _____ | |

Why did you leave your last dentist? _____

Please identify any allergies or sensitivities:

- | | | | |
|-------------------------------------|--------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Other _____ | | |

I hereby state that the above information is accurate and correct to the best of my knowledge. I hereby authorize and consent to have Dr. Sanfelippo diagnose and administer treatment.

Signature _____ Date ___/___/___