Dr Patrick Piovesan, D.M.D, P.C.
Family and Cosmetic Dentistry

Medical History

Name: _____ Date of Birth _____S.S. Number_____
Date of Last Dental Visit: _____ Reason for this visit _____

Have you ever had any of the following? Please check YES OR NO:

Yes☐ or NO☐	AIDS or HIV	**Yes☐ or NO☐**	Glaucoma	**Yes☐ or NO☐**	Nervous Disorders	**Yes☐ or NO☐**	Tumors
Yes☐ or NO☐	Allergies	**Yes☐ or NO☐**	Excessive Bleeding	**Yes☐ or NO☐**	Pacemaker	**Yes☐ or NO☐**	Ulcers
Yes☐ or NO☐	Anemia	**Yes☐ or NO☐**	Hay Fever	**Yes☐ or NO☐**	Angina	**Yes☐ or NO☐**	Take blood thinners
Yes☐ or NO☐	Artificial Joints	**Yes☐ or NO☐**	Head Injuries	**Yes☐ or NO☐**	Thyroid Problems	**Yes☐ or NO☐**	Codeine Allergy
Yes☐ or NO☐	Asthma	**Yes☐ or NO☐**	Heart Disease	**Yes☐ or NO☐**	Radiation Treatment	**Yes☐ or NO☐**	Aspirin Allergy
Yes☐ or NO☐	Blood Disease	**Yes☐ or NO☐**	Heart Murmur	**Yes☐ or NO☐**	Respiratory Problem	**Yes☐ or NO☐**	Penicillin Allergy
Yes☐ or NO☐	Cancer	**Yes☐ or NO☐**	Hepatitis/Jaundice	**Yes☐ or NO☐**	Rheumatic Fever	**Yes☐ or NO☐**	Swollen Ankles
Yes☐ or NO☐	Diabetes	**Yes☐ or NO☐**	High Blood Pressure	**Yes☐ or NO☐**	Rheumatism	**Yes☐ or NO☐**	S.T.D.
Yes☐ or NO☐	Dizziness	**Yes☐ or NO☐**	Jaundice	**Yes☐ or NO☐**	Sinus Problems	**Yes☐ or NO☐**	Mitral Valve Prolapse
Yes☐ or NO☐	Epilepsy	**Yes☐ or NO☐**	Kidney Disease	**Yes☐ or NO☐**	Stomach Problems		
Yes☐ or NO☐	Growths	**Yes☐ or NO☐**	Liver Disease	**Yes☐ or NO☐**	Stroke	**Yes☐ or NO☐**	Redux/Fen-Fen use
Yes☐ or NO☐	Fainting	**Yes☐ or NO☐**	Mental Disorders	**Yes☐ or NO☐**	Tuberculosis		

If you answered "Yes" to any of these questions, please explain:_____
_____

• Have you ever had any complications following dental treatment? **Yes ☐ or NO ☐**
If yes, please explain: _____ _____

• Have you been admitted to a hospital or needed emergency care during the past two years? **Yes ☐ or NO ☐** If yes, please explain:
_____

• Are you now under the care of a physician? **Yes ☐ or NO ☐** If yes, please explain: _____
• Name of Physician: _____Phone: _____

• Do you have any health problems that need further clarification? **Yes ☐ or NO ☐**
If yes, please explain: _____

• What is your general state of health? _____

• List of known allergies: _____ _____

• Are you currently taking any medication? **PLEASE LIST** _____

• Have you used recreational or street drugs (I.e. Marijuana) **Yes ☐ or NO ☐**

• Do you consume alcoholic beverages? How often? How Much? **Yes ☐ or NO ☐** _____

• Do you smoke or chew tobacco? How often? How much? **Yes ☐ or NO ☐** _____

• Have you ever had: Tooth Aches _____ Orthodontics_____ Root Canals _____
Periodontal Work_____ Extractions _____ Injury to teeth/jaws_____

• Do you have a family history of: Diabetes_____ Bleeding Disorders _____Heart Disease_____ Cancer_____

• Females:
Are you pregnant? Estimated due date?_____

Are you currently on birth control? _____ Are you taking oral contraceptives? _____

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Dental History

• Do your gums bleed when you brush? _____
• Are your teeth sensitive to hot or cold? _____
• Do you feel pain in any of your teeth? _____
• Do you have lumps or sores in or near your mouth? _____
• Have you experienced any problems with your jaw (i.e. Clicking, pain, difficulty chewing) _____
• Have you had any head or neck injuries? _____
• How many pillows do you use at night to sleep with? _____
• Do you have' frequent headaches? _____
• Do you clench or grind your teeth? _____
• Do you bite your lips or cheeks frequently? _____
• Do you wear dentures or partials? _____
• Have you ever received oral hygiene instructions regarding the care of your teeth and gums? _____
• Do you like your smile? _____

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To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I authorize and give consent to any dental exam, anesthetic, operation or treatment that is necessary for treatment and diagnosis of the above named patient.

_____Date: _____
Signature of patient, parent or guardian

SUMMARY AND MEDICAL RISK ASSESMENT (To be completed by dentist):

_____
_____
_____
_____

Physical (PS) Status _____

_____
Patient Signature and Date Dr. Patrick Piovesan Signature and Date

Health History Update (for future annual exams)

Health history has been updated and changes have been noted.
1. _____Date: _____
2. _____Date: _____
3. _____Date: _____
4. _____Date: _____
5. _____Date: _____

Medical Consult Summary (to be completed by dentist)

_____
_____
_____
_____
_____