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□**	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□**	Penicillin Allergy
Yes□ or NO□	Blood Disease	**Yes□ or NO□**	Heart Murmur	**Yes□ or NO□**	Respiratory Problem	**Yes□ or NO□**	Aspirin
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? _____

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

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? _____

==========

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)

_____
_____
_____
_____
_____