DiChristofano & DiChristofano
QUALITY DENTISTRY, COMPASSIONATE CARE

Dr. Robert DiChristofano
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Adult Medical History

Patient's name ____
Last First Initial Date of Birth

Physician's name ____
Phone ____

Questions:	Yes	No
1. Are you under the care of a physician? ---	☐	☐
If so, why? ____		
2. When was your last complete physical exam? ____________________		
3. Are you taking any medications? ---	☐	☐
If so, please list the medicine, the amount, and how often it is taken. If necessary please use the additional comments section for further listing.		
____		
____		
____		
____		
____		
4. Do you routinely take health related substances? ------------------------------ (vitamins, herbal supplements, natural products…)	☐	☐
5. Have you ever had a serious illness or major surgery? -------------------------	☐	☐
If so, please explain ____		
____		
____		
6. Have you ever been told to pre-medicate before dental appointments?	☐	☐
7. Are you allergic to any medications or substances? ---------------------------- (Please list any allergies in the additional comments section)	☐	☐
8. Do you have any problems taking penicillin, antibiotics, anesthetics, or other medications? ---	☐	☐

9. Are you sensitive to any metals or latex? --- ☐ ☐

10. Are you pregnant or suspect you may be? -------------------------------------- ☐ ☐

11. Do you use any birth control medications? ------------------------------------ ☐ ☐

Questions:	**Yes**	**No**
12. Have you ever been treated for or been told that you have heart disease, had a heart attack, or a heart murmur? -------------------------------	☐	☐
13. Do you have a pacemaker, an artificial heart valve or been diagnosed with mitral valve prolapse? --	☐	☐
14. Have you ever had any strokes? ---	☐	☐
15. Have you ever had rheumatic fever?--	☐	☐
16. Are you aware of any heart abnormalities? ------------------------------------	☐	☐
17. Do you have high or low blood pressure? --------------------------------------	☐	☐
18. Have you ever had any blood transfusions? -----------------------------------	☐	☐
19. Do you have any blood disorders such as anemia, leukemia, etc… --------	☐	☐
20. Have you ever had cancer? ---	☐	☐
21. Have you ever had radiation treatment, and/or chemotherapy for any condition? --	☐	☐
22. Have you ever taken Fosamax, Zometa, Actonel, Boniva, Skelid, Didronel, Aredia or any other oral or intravenous treatment (Bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis? --	☐	☐
23. Do you have inflammatory diseases, such as arthritis or rheumatism?	☐	☐
24. Do you have any artificial joints/prosthesis or heart valves? --------------	☐	☐
25. Have you ever bled excessively after being cut or injured? ------------------	☐	☐
26. Did you ever have any stomach or ulcer problems?---------------------------	☐	☐
27. Did you ever have any kidney problems?--	☐	☐
28. Did you ever have any respiratory or sinus problems? ----------------------	☐	☐

29. Did you ever have any thyroid problems? --------------------------------------- ☐ ☐

30. Did you ever have any liver problems? --- ☐ ☐

Questions:	Yes	No
31. Have you ever had or do you test positive for Hepatitis? -------------------	☐	☐
32. Are you a diabetic? ---	☐	☐
32.a. Were you ever told you were borderline or pre-diabetic? -----------	☐	☐
33. Do you have fainting or dizzy spells? ---	☐	☐
34. Do you have asthma or breathing difficulties? ---------------------------------	☐	☐
35. Do you have epilepsy or seizure disorders? -------------------------------------	☐	☐
36. Do you have or have you ever had a sexually transmitted disease?-------	☐	☐
37. Have you tested HIV positive? ---	☐	☐
38. Do you have AIDS? --	☐	☐
39. Do you have or have you had tuberculosis(TB)? --------------------------------	☐	☐
40. Do you smoke, chew, use snuff or any other forms of tobacco? -----------	☐	☐
41. Do you regularly consume more than one or two alcoholic beverages a day? --	☐	☐
42. Do you habitually use controlled substances? ---------------------------------	☐	☐
43. Have you had psychiatric treatment? ---	☐	☐
44. Have you ever taken Fen-Phen, Redux, or other appetite suppressant drugs? ---	☐	☐
45. Do you have any disease condition, or problem not listed? If so, please explain. ____	☐	☐
46. Is there anything else we should know about your health that we have not covered in this form? ____	☐	☐

47. Would you like to speak with the Dr. privately about any problems? ☐ ☐

Comments:

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I certify that the above information is complete and accurate.

Patient/ Guardian's signature ________________________________ **Date** __________

Dentist's signature ____ **Date** __________