MATT **BOLAMPERTI**, D.D.S.
Cosmetic & Family Dentistry

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MEDICAL HISTORY

Patient Name: _____

Do you have a personal physician? ☐ Yes ☐ No

Name:_____ Phone:_____

Are you under a physician's care now? ☐ Yes ☐ No

If yes, please explain:_____

_____

Are you currently taking any medications, pills or drugs? ☐ Yes ☐ No

If yes, please list:_____

_____

_____

_____

_____

Are you taking or have you ever taken any biophosphonate drugs to treat bone disorders, including osteoporosis? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No ☐ Possibly

Are you taking oral contraceptives? ☐ Yes ☐ No

Do you need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No

(This is to prevent bacterial endocarditis after joint replacement or due to congenital heart disease, prosthetic heart valves or other heart conditions; final confirmation of the need for pre-medication should be made by your physician).

Have you had any serious medical problems in the last 5 years? ☐ Yes ☐ No

If yes, please explain:_____

_____

Do you have, or have you ever had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma/Respiratory problems
- ☐ Blood disease
- ☐ Cancer/Tumors
- ☐ Chemo/Radiation
- ☐ Cold sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Dental anxiety
- ☐ Diabetes
- ☐ Drug/alcohol abuse
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart surgery
- ☐ Hemophilia/Bleeding
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve prolapse
- ☐ Pacemaker
- ☐ Psychiatric Disorders
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sickle-cell Disease
- ☐ Sinus trouble
- ☐ Stomach disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ TMJ (jaw pain)
- ☐ Transplant
- ☐ Venereal Disease/STD's
- ☐ Vision problems
- ☐ Xerostomia (dry mouth)
- ☐ NONE

Have you experienced any serious illness/condition not listed above?

☐ Yes ☐ No If yes, please explain:_____

_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Clindamycin

☐ Sulfur ☐ Cephalosporins ☐ Latex ☐ Local anesthetics

☐ Other, please list:_____

DENTAL HISTORY

Why have you come to the dentist today?_____

_____

Date of last dental visit?_____Last dental cleaning?_____Last x-rays?_____

How often do you brush?_____ How often do you floss?_____

Do you have active dental problems now? ☐ Yes ☐ No

If yes, please describe:_____

Do you experience trouble with bad breath? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do your jaws ever feel tired? ☐ Yes ☐ No

Does it hurt when you chew or open wide to take a bite? ☐ Yes ☐ No

Do you have any jaw symptoms or headaches upon awaking in the morning? ☐ Yes ☐ No

Have you ever had:

- ☐ Periodontal treatment
- ☐ Oral Surgery/Teeth removed
- ☐ Root canal Therapy
- ☐ A bite splint/mouth guard
- ☐ Missing teeth
- ☐ Broken jaw

Are your teeth sensitive to: Hot, Cold, Sweets, Chewing (circle)?

Do you like your smile? ☐ Yes ☐ No

If no, what would you like to change?_____

_____

_____

Have you ever whitened your teeth? ☐ Yes ☐ No

Would you like to hear about whitening options? ☐ Yes ☐ No

Do you have any silver fillings that you would like replaced with tooth colored restorations? ☐ Yes ☐ No

Do you have any special questions or concerns ☐ Yes ☐ No

_____

_____

To the best of my knowledge, the questions on this form have been answered accurately. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform the dental office of any changes.

HIPPA ACKNOWLEDGMENT	
PATIENT RECEIVED	PATIENT REFUSED

_____

Patient (Guardian) **Signature** **Date**

_____

Patient (Guardian) **Print Name** **Date**

UPDATES:_____

_____

_____

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_____

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continued on back page

UPDATES: