James R. Pignataro, III., D.D.S.

MEDICAL HISTORY

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Patient's Name _____ **Age**_____ **Today's Date**_____

Phone Number_____ **Incoming Bp**_____ **Pulse**_____ **Chart Number**_____

Please check only the BOX for any condition you have had in the past or have now.

	Box			Box	
CARDIOVASCULAR		DR. COMMENTS	RESPIRATORY		DR. COMMENTS
High Blood Pressure			Hay Fever		
Heart Failure			Sinus Trouble		
Heart disease/attack		When _____	Allergies/hives		
Angina or chest pain		Nitro tabs _____	Asthma		Inhaler use _____
Heart murmur		Angiogram	Emphysema		O2 therapy_____
Mitral valve prolapse		Pre-med _____	Bronchitis		
Endocarditis			Tuberculosis		Skin test date _____
Congenital heart defect			Breathing difficulties		When_____
Artificial heart valve			DERMATOLOGIC		
Arrythmias			Allergy to latex		
Pacemaker/defibrillator			Allergy to food or drugs		Types_____
Heart surgery		Type_____	Skin rash		Location_____
Blood thinners		Type_____	Fever blisters		Frequency_____
Aneurysm			Canker sores		
Shortness of breath			ENDOCRINE		
Swollen ankles			Diabetes		Type_____
Sleep disorder			Thyroid disease		Hyper_____Hypo_____
HEMATOLOGIC			Have taken steroids		
Blood transfusion		When_____	GENITOURINARY		
Anemia			Kidney problems		
Hemophilia			Dialysis		
Leukemia			Sexually transmitted diseases		Type_____
Sickle cell disease			MUSCULOSKELETAL		
Bleeding tendencies			Arthritis		
NEUROLOGIC			Artificial joints		Surg. date_____
Glaucoma			Bone disorders		
Vision problems		Glasses_____Contacts_____	Muscle disorders		
Hearing loss			OTHER		
Severe headaches			Prostate problems (Males)		
Fainting spells			HIV-positive		
Stroke / CVA			IV drug addiction		
Seizures / Epilepsy			Drug addiction		Type_____
Psychiatric treatment			Do you drink alcohol		How often_____
GASTROINTESTINAL			Tumor or cancer		
Stomach ulcers			X-ray or cobalt treatment		Location_____
Gastrtis/colitis			Chemotherapy		
Hepatitis		Type_____	Organ transplant		Type_____
Liver disease			Use tobacco		Type_____How much_____
Yellow jaundice			Unexplained weight loss/gain		
Cirrhosis			Other conditions not listed		
Eating Disorders			Reaction to gen. Anesthesia		
Diet suppressants			SPECIFIC DRUG ALLERGIES		
WOMEN (only)			Local anesthetics		Type_____
Pregnant (currently)		Trimester_____	Antibiotics		Type_____
Breast feeding (currently)			Codeine / Narcotics		Type_____
Use of oral contraceptives			Aspirin / NSAIDS		Type_____

PLEASE COMPLETE THE OTHER SIDE

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Patient's Name_____ MEDICAL HISTORY cont'd

Are you currently under the care of a physician? Yes ( ) No ( )
Please give the following concerning your primary physician.

Physician name _____
Address _____
Phone number _____
Date of last visit_____

Have you ever been hospitalized or had any operations? Yes ( ) No ( )
If (yes), give approximate year and reason below.

YEAR	REASON

Are you currently taking any prescribed medications, herbals or over-the-counter drugs? Yes ( ) No ( )
If (yes) please list below.

CURRENT	Dr. only...UPDATES

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail. ***To aid in safely treating me, I give my permission to consult other health care providers concerning my health history should the need arise.***

_____
Patient Signature Date

DOCTOR USE ONLY BELOW THIS LINE

ASA Class ( ) I ( ) II ( ) III ( ) IV

Med Hx Updates

Date:	BP	P	Date:	BP	P
Date:	BP	P	Date:	BP	P