



Aesthetics
 Prosthodontics
 Periodontics
 Implant Dentistry

Graziano D. Giglio, D.D.S.
 Ana Becil Giglio, D.D.S.

MEDICAL HISTORY FORM

Date

Name Home Phone ()

Address Business Phone ()

City State Zip Code Cell Phone ()

Email Preferred contact number

Occupation Social Security Number

Date of Birth/...../..... Sex M F Height Weight Single Married

Name of Spouse

Closest Relative Phone ()

Referred by

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? Yes No

2. Has there been any change in your general health within the past year? Yes No

3. My last physical examination was on/...../.....

4. Are you now under the care of a physician? Yes No

If so, what is the condition being treated?

5. The name and phone # of my physician(s) is

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

If so, what was the illness or problem?

7. Are you taking any medicine(s) including non-prescription medicine? Yes No

If so, what medicine(s) are you taking?

8. Do you have or have you had any of the following diseases or problems?

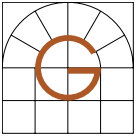
a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes No

1. Do you have chest pain upon exertion? Yes No

2. Are you ever short of breath after mild exercise or when lying down? Yes No

3. Do your ankles swell? Yes No



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4. Do you have inborn heart defects? Yes No

5. Do you have a cardiac pacemaker? Yes No

c. Allergy Yes No

d. Sinus trouble Yes No

e. Asthma or hay fever Yes No

f. Fainting spells or seizures Yes No

g. Persistent diarrhea or recent weight loss Yes No

h. Diabetes Yes No

i. Hepatitis, jaundice or liver disease Yes No

j. AIDS or HIV infection Yes No

k. Thyroid problems Yes No

l. Respiratory problems, emphysema, bronchitis, etc. Yes No

m. Arthritis or painful swollen joints Yes No

n. Stomach ulcer or hyperacidity Yes No

o. Kidney trouble Yes No

p. Tuberculosis Yes No

q. Persistent cough or cough that produces blood Yes No

r. Persistent swollen glands in Yes No

s. Low blood pressure Yes No

t. Sexually transmitted disease Yes No

u. Epilepsy or other neurological disease Yes No

v. Problems with mental health Yes No

w. Cancer Yes No

x. Problems of the immune system Yes No

9. Have you had abnormal bleeding? Yes No

a. Have you ever required a blood transfusion? Yes No

10. Do you have any blood disorder such as anemia? Yes No

11. Have you ever had any treatment for a tumor or growth? Yes No

12. Are you allergic or have you had a reaction to:

a. Local anesthetic's Yes No

b. Penicillin or other antibiotics Yes No

c. Sulfa drugs Yes No

d. Barbiturates, sedatives, or sleeping pills Yes No

e. Aspirin Yes No

f. Lodine Yes No

g. Codeine or other narcotics Yes No

h. other Yes No

13. Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, please explain

.....

.....

14. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

If so, please explain

.....

.....

15. Are you wearing contact lenses? Yes No

16. Are you wearing removable dental appliances? Yes No

Women

18. Are you pregnant? Yes No

19. Do you have any problems associated with your menstrual period? Yes No

20. Are you nursing? Yes No

21. Are you taking birth control pills? Yes No

Tobacco Use

22. Do you smoke? Yes No

If so, please elaborate

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For Completion by the dentist

Comments on patient interview concerning medical history:

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Significant findings from questionnaire or oral interview:

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Dental management considerations:

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Date: Signature of Dentist:

Medical History Update:

Date:

Comments:

.....

.....

Signature:

Date:

Comments:

.....

.....

Signature: