Dr. Gene DeStefano

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Medical History

1. Are you under medical treatment now? ◯ Yes ◯ No

If yes, please explain:

_____

_____

2. Have you had any major surgeries or serious illness? ◯ Yes ◯ No

If yes, please explain:

_____

_____

3. Women only:

◯ Are you pregnant or think you may be pregnant? ◯ Are you nursing? ◯ Are you taking oral contraceptives?

◯ None apply

4. Do you have allergies or any reactions to the following?

☐ Local anesthetics (e.g. Novocain) ☐ Penicillin or any antibiotics ☐ Sulfa drugs

☐ Codiene/Narcotics ☐ Aspirin ☐ Any metals (e.g. Nickel, Mercury, etc.)

☐ Latex rubber ☐ Other (please list)

5. Please check which pertain to Your Medical Health:

☐ High Blood Pressure ☐ Low Blood Pressure ☐ History of Stroke

☐ Asthma ☐ Emphysema ☐ Tuberculosis

☐ Persistent Cough or Throat Clearing ☐ History of Heart Disease ☐ History of Bacterial Endocarditis

☐ Cardiac Pacemaker ☐ Artificial Heart Valve ☐ Angina/ Chest Pain

☐ Swollen Ankles ☐ Sexually Transmitted Diseases ☐ AIDS/HIV Infection

☐ History of Liver Disease ☐ Hepatitis A,B, or C ☐ Digestive Problem

☐ Ulcers ☐ Colitis ☐ Diabetes

☐ Kidney Disease ☐ Neurological Problems ☐ Eye Disorders

☐ Epilepsy/Convulsions ☐ Seizures ☐ Fainting

☐ Arthritis ☐ Joint Replacement or Implant ☐ Radiation Therapy

☐ Thyroid Problems ☐ Anemia ☐ Extreme/Prolonged- Fatigue

☐ History of Sleep Apnea ☐ Recent Weight Loss or Gain ☐ Smoking/Chewing Tobacco

☐ Chemical Dependency ☐ Other

6. Are you taking any medication(s) including non-prescription medicine? Please list:

_____

_____

_____

7. In case of an Emergency, who may we contact? Please provide their telephone number and your relationship to this contact.

_____

_____

8. Physician's Name - Office Address and Phone Number:

_____

_____

9. Prefered Pharmacy's Name - Address and Telephone Number:

_____

_____

Dental History

Please indicate date of last dental visit and reason for visit today.

_____

_____

1. Please check which pertain to your Dental Health:

- ☐ Bleeding while brushing/flossing
- ☐ Sore/Painful teeth
- ☐ Loose teeth
- ☐ Bad breath/Bad taste
- ☐ Clench/Grind teeth
- ☐ Gag easily
- ☐ Difficulty chewing
- ☐ Previously unfavorable dental experience
- ☐ Sensitivity to hot/cold
- ☐ Sores/Lumps/Blisters in or on mouth
- ☐ Food is trapped around/ between teeth
- ☐ Frequent headaches
- ☐ Dental anesthetics: Ineffective/ Bad reaction
- ☐ Jaw joint/Ear pain
- ☐ Received oral hygiene instruction
- ☐ Sensitivity to sweets
- ☐ Biting: lip/cheek/tongue
- ☐ Dry mouth/Excessive thirst
- ☐ Head/Neck/Jaw injuries
- ☐ Post- Extraction: Prolonged bleeding/Dry socket
- ☐ Difficulty opening/closing jaw
- ☐ Unhappy with dental appearance

Periodontal (gum) treatment, when:

_____

Orthodontic treatment (braces), when:

_____

Response Date: _____