Matthew Bagnulo, DDS | Family Dentist

DENTAL HEALTH HISTORY QUESTIONNAIRE

Today's Date_____

Patient's Last Name_____First Name_____Middle Initial_____

Male / Female Patient's birthday_____

Primary Physician_____ Physician's Phone number_____

What is the reason for your visit today?_____

Have you ever had any unusual reactions or complications related to dental treatment? Yes / No

Please explain:_____

Are you allergic or have you had a reaction to the following?

Latex: Yes / No

Penicillin or other antibiotics: Yes / No

Aspirin, Ibuprofen, or Tylenol: Yes / No

Local Anesthetics: Yes / No

Are you currently seeing a doctor? Yes / No

If yes, Please explain: _____

Have you ever had a serious illness, operation, or been hospitalized? Yes / No

If yes, Please explain: _____

Are you taking any medications, pills, or over the counter medicines at this time? Yes / No

If yes, please list: _____

Do you have allergies to any other medications? Yes / No

If yes, please list: _____

Women:
Are you Pregnant? Yes / No

Are you nursing? Yes / No

Are you taking oral contraceptives? Yes / No

Are you taking hormone supplements? Yes / No

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Do you now have or have you had any of the following conditions?

CONDITION	YES	NO
Heart Problems		
Heart Murmur		
Chest Pains		
Artificial Joints/Valves		
High Blood Pressure		
Arterial Stents/Grafts		
Pacemaker		
Stroke		
Osteoporosis		
Diabetes		
Glaucoma		
Arthritis		
Kidney Problems		
Undergoing Dialysis		
Rheumatic Fever		
AIDS/HIV positive		
Anemia		
Bleeding Problems		

CONDITION	YES	NO
Ulcers		
Tumor/Cancer		
Radiation Therapy		
Thyroid Problems		
Transplant (bone/organ)		
Bisphosphonates		
Lung disease		
Asthma		
Respiratory Problems		
TB/Tuberculosis		
ADD/ADHD		
Psychiatric Care		
Seizure Disorder/Epilepsy		
Hepatitis/Jaundice		
Liver Disease		
Alcoholism/Drug Abuse		
Dizziness/Fainting		
Herpes		
Tobacco Use		

Consent: The undersigned hereby authorizes the doctor or his staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor or staff to perform any and all forms of treatment, medication and therapy, which may be indicated in connections with _____(Name of Patient) and further authorize and consent that the doctor choose and employ any assistance deemed fit. I also understand that the use of anesthetic agents embodies a certain risk.

_____
[Date]

_____
[Printed Name of Patient, Parent or Guardian]

_____
[Signature of Patient, Parent or Guardian]

_____
[Date]

_____
Matthew Bagnulo, DDS