Anna C. Giacalone, D.M.D. 100 Ridge Road, Suite 36, Chadds Ford, PA 19317 610-558-1760(Fax: 610-558-0970)

Patient Name:_____Date of Birth:_____

MEDICAL HISTORY:

YES NO

1. Have you been treated by a physician or stayed overnight in the hospital in the past year?
   If so, describe:_____
   _____
2. Have there been any changes in your general health in the past year?
   Approximate date of your last physical examination:_____
3. Are you being treated for any conditions by a physician now?
   If so, what? _____
4. List all medications or drugs you are taking at the present time:

Medications	Dosage	For what purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are you allergic to penicillin?
6. Are you allergic to latex?
7. Has anyone told you not to take a particular drug (aspirin, Novocaine, codeine, sulfa, etc.)?
   Are you allergic to any other medicines? If so, list:_____
   _____
8. Have you ever had jaundice or hepatitis?
9. Have you ever had TB (tuberculosis) or lived with anyone who had TB?
10. Do you have any artificial joints?
11. Have you ever been told you had any of the following? Circle all that apply.

Rheumatic Fever	High or Low Blood Pressure	Psychological Problems
Heart Murmur	Diabetes	Any kind of Blood Disorder
Heart Attack or Coronary	Kidney Disease	or Bleeding Problems
Angina	Epilepsy or Seizures	Chemical Dependency
Mitro Valve Prolapse	Joint Replacement	or Alcoholism

12. Are you taking presently or have you ever taken a drug for osteopenia or osteoporosis?
    (Actonel, Boniva, Reclast, Fosamax) Name of medication:_____
    How long were you taking this medication?_____
13. Have you ever experienced any problem with local anesthesia (Novocaine)?

For Women: 14. Are you now pregnant or think you are pregnant? Yes____ No___

15. Is there any other medical condition which was not asked, which you feel may influence dental treatment? If so, what? _____
    _____

Signature:_____ Date:_____

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Patient Name:_____ Date of Birth_____

Dental History:

Do you have any dental condition which you believe requires immediate attention today?
Please describe: _____
_____

Yes No

☐ ☐ 1. Have you ever had a complete series of x-rays taken of your teeth?
If so, when was the last time?_____
☐ ☐ 2. Have you often had severe toothaches?
☐ ☐ 3. Have you ever had treatment for your gums?
☐ ☐ 4. Are you satisfied with the appearance of your teeth?
☐ ☐ 5. Do your gums bleed or hurt when you brush them?
☐ ☐ 6. Have you been aware of any bad odor or taste in your mouth?
☐ ☐ 7. Are your teeth sensitive to heat, cold, or sweets?
☐ ☐ 8. Do any teeth hurt when you chew?
☐ ☐ 9. Have your teeth moved or drifted from their normal position?
☐ ☐ 10. Do you clamp, clench, or grind your teeth during the day or night?
☐ ☐ 11. Have you ever had troublesome pain in your jaw joint?
☐ ☐ 12. Does your jaw pop or click?
☐ ☐ 13. Have you ever had difficulty opening or closing your mouth?
☐ ☐ 14. Do you frequently get headaches? How often-daily, weekly, monthly?
☐ ☐ 15. Do you snore?
☐ ☐ 16. Have you ever been diagnosed with sleep apnea?
☐ ☐ 17. Do you wake up tired in the morning?
☐ ☐ 18. Do you frequently fall asleep sitting up watching TV or riding in a car?
☐ ☐ 19. What is the main reason you are here?_____
_____

It is our goal to make your visits here a comfortable experience. Please inform us of any special needs which we might address:_____
_____

Date:_____ Signature_____

DR.'S NOTES-SIGNIFICANT FINDINGS

BP	Pulse

_____
_____
_____
_____