MEDICAL HISTORY

JOSEPH C. PIGNATARO D.M.D.
VICTORIA J. PIGNATARO D.M.D.

PIGNATARO FAMILY DENTISTRY, P.C.
7950 Hwy 72 W. • Suite F • Madison, AL 35758
Telephone: (256) 837-1971

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