DE FELICE DENTISTRY

Dr. Louise C. De Felice, DDS
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PATIENT MEDICAL HISTORY

Date:_____

Patient's Name:_____
Last First Middle

Date of Birth:_____ Social Security #_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Gender: ☐ Male ☐ Female

Primary Care Physician:_____ Phone:_____

Address: _____
Street city/state zip code

Date of last physical:_____

Pharmacy:_____ Phone:_____

If female, please answer:

Y	N	
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant? If yes, # of weeks:
☐	☐	Are you nursing?

Please answer the following:

Do you smoke or use tobacco?
☐ Yes ☐ No

Height: Weight:

Please check Y (yes) or N (no) for each condition & allergy

Y	N		Y	N		Y	N	**Allergies:**
☐	☐	Abnormal Bleeding	☐	☐	Rheumatic Fever	☐	☐	Aspirin
☐	☐	Angina Pectoris	☐	☐	Seizures	☐	☐	Codeine
☐	☐	Artifical Heart Valve	☐	☐	Sinus Prblems	☐	☐	Dental Anesthetics
☐	☐	Artificial Joints	☐	☐	Stroke	☐	☐	Erythromycin
☐	☐	Asthma	☐	☐	Thyroid Problems	☐	☐	Jewelry
☐	☐	Cancer-Chemotherapy	☐	☐	Tuberculosis	☐	☐	Latex
☐	☐	Congenital Heart Defect	☐	☐	Mercury Fillings	☐	☐	Metals
☐	☐	Diabetes	☐	☐	Fluoride Free	☐	☐	Penicillin
☐	☐	Drug Abuse	☐	☐	Interested in Changing Smile	☐	☐	Tetracycline
☐	☐	Emphysema	☐	☐	Keep Remaining Teeth	**OTHER:**		
☐	☐	Epilepsy	☐	☐	Bleeding Gums			
☐	☐	Fever Blisters	☐	☐	Floss Regularly			
☐	☐	HIV+AIDS	☐	☐	Clenching or Grinding			
☐	☐	Heart Attack	☐	☐	Frequent Headaches			
☐	☐	Heart Surgery	☐	☐	Pain in Jaw Joints			
☐	☐	Hemophilia	☐	☐	History of Trauama to the Face			
☐	☐	Hepatitis A	☐	☐	Snoring			
☐	☐	Hepatitis B	☐	☐	Snoring that Disrupts Others			
☐	☐	Hep C	☐	☐	Fatigue During Day			
☐	☐	High Blood Pressure	☐	☐	Sleep Apnea			
☐	☐	Kidney Problems	☐	☐	Tooth Pain			
☐	☐	Liver Disease	☐	☐	Face Pain			
☐	☐	Pace Maker	☐	☐	Take Nutritional Supplements			
☐	☐	Psychiatric Problems	☐	☐	Used Botox			
☐	☐	Radiation Therapy	☐	☐	Used Dermal Fillers			

PLEASE COMPLETE BACKSIDE

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Please list all medications below:

Y N ☐ ☐ Is there any disease condition, or problem you feel the office should know about that is not covered above? If yes, Please describe below:

Notes:

For Office Use Only:

Medical Allerts:

BP

Heart Rate:

Signature:_____ Date:_____

(if under 18, parent or guardian signature required)