167 Village Street
Medway, Massachusetts 02053
Telephone: (508) 533-6400
Fax: (508) 533-6400
www.MedwayVillageDentist.com

PATIENT HISTORY FORM

Patient Information

Patient's Name: ____ SSN:______________________________

(Last, First, Middle)

Date of Birth: ____________ Age: ______ Sex: ☐Male ☐Female Ht: ______ ' ________ " Wt: ___________ lbs

Patient Address: ____

(City, State, Zip Code)

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed Do you smoke or use tobacco? ☐Yes ☐No

If female, are you pregnant? ☐Yes ☐No If yes, how many weeks: ____________ Are you nursing? ☐Yes ☐No

Are you taking Birth Control Pills? ☐Yes ☐No

Pharmacy Used: ____ Pharmacy Phone:_____________________

Dental History

Are you having any discomfort at this time? ☐Yes ☐No

How long has it been since you have seen a dentist? ____

How long has it been since your last cleaning? X-rays? ____

Have you ever had gum treatments? ☐Yes ☐No When? ____

Are your teeth sensitive to: ☐Heat ☐Cold ☐Sweets ☐Pressure?

Where?____

____

Do you currently have bleeding gums? ☐Yes ☐No

Does food wedge between your teeth? ☐Yes ☐No Where?____

Do you clench or grind your teeth? ☐Yes ☐No When?____

Are there any lumps or swelling in your mouth? ☐Yes ☐No

Do you have any pain in or around your ears or frequent headaches? ☐Yes ☐No

Do you hear popping, clicking, or snapping when you chew? ☐Yes ☐No

Do you have any fear of dental treatment? ☐None ☐Mild ☐Moderate ☐Severe

Are you comfortable having dental treatment with only local anesthetic? ☐Yes ☐No

Have you had any problems in the past with any type of Anesthesia? ☐Yes ☐No

Are there any fillings, caps, or teeth you don't like looking at and would like to change? ☐Yes ☐No

Do you like your smile? ☐Yes ☐No If no, why? ____

____

What is the reason for today's visit? ____

____

Thomas P.A. Carchidi, D.M.D.
FAMILY DENTISTRY

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Medical History

Physician's Name:____ Phone:______________________

Date of last physical exam: ___________________________ Reason? ________________________________

Are you taking any medications prescribed by a physician? ☐Yes ☐No List any medications and dosages? _______

____

____

____

Are you taking any other drugs or natural herbal medicines not prescribed by a doctor? ☐Yes ☐No

Please list any medicine, supplement, or herbal remedies you are currently or have taken in the past 2 years not prescribed by a physician: ____

____

____

Have you been hospitalized or treated for a serious illness in the last two years? ☐Yes ☐No What?_____________

____

Have you ever taken any of the following medicine Alendronate (Fosamax), Ibandronate (Boniva), Risedronate (Actonel), Zolendronic acid (Reclast) or any other bisphosphonate? ☐Yes ☐No

Do you have any of the following? (Please indicate yes with a check mark)

AIDS or HIV positive	☐	Drug Addiction	☐	Low Blood Pressure	☐
Allergies to Bananas or Nuts	☐	Emphysema	☐	Malignancies (Cancer)	☐
Anemia	☐	Epilepsy/Seizures	☐	Mitral Valve Prolapse	☐
Angina	☐	Excessive Bleeding	☐	Nervous Problems	☐
Arthritis	☐	Fainting or Dizzy Spells	☐	Organ Transplant	☐
Artificial Heart Valve	☐	Glaucoma	☐	Psychiatric Care	☐
Artificial Joint	☐	Heart Attack	☐	Radiation Treatments	☐
Asthma	☐	Heart Disease	☐	Rheumatic Fever	☐
Chemotherapy	☐	Heart Murmur	☐	Sinus Problems	☐
Circulatory Problems	☐	Heart Pacemaker	☐	Smoke or Dip Snuff	☐
Cold Sores	☐	Hemophilia	☐	Stroke	☐
Congenital Heart Defect	☐	Hepatitis A/B/C	☐	Thyroid Problems	☐
Cortisone Medicine	☐	Herpes	☐	Tuberculosis	☐
Diabetes	☐	High Blood Pressure	☐	Ulcer	☐
Difficulty Breathing	☐	Liver Disease	☐	Venereal Disease	☐

Are you allergic to any of the following? (Please indicate yes with a check mark)

Amoxicillin / Penicillin	☐	Dental or Topical Anesthetics	☐	Latex	☐
Aspirin	☐	Erythromycin	☐	Tetracycline	☐
Codeine	☐	Jewelry/Metals	☐	Other	☐

I permit the release of any information to or from my physician as may be required and attest that the health history is accurate and fully disclosed to the best of my knowledge.

_____________________________ _____________________________ _______________

(Signature of Patient, Parent or Guardian) (Signature of Dentist/Witness) (Date)