ANTHONY C. FRAGOLA, D.D.S.

"PATIENT INFORMATION" DATE: ____________

CIRCLE: Miss. Mr. Mrs. Ms. REFERRING DENTIST: ______________________

LAST NAME: ______________________ FIRST: ____________ MIDDLE: ____________

ADDRESS: ______________________ CITY: ____________ ZIP CODE: ________

HOMEPHONE: ____________ DATE OF BIRTH: ____________ S.S. # ______________

OCCUPATION: ______________________ BUSINESS PHONE: ______________

NAME/ADDRESS OF BUSINESS: ______________________________

PARENTS OR SPOUSE'S 1st NAME: ______________________ S.S. #: ______________

PHYSICIAN'S NAME/ADDRESS/PHONE: ______________________ DATE OF LAST EXAM: ____________

ARE YOU UNDER MEDICAL CARE? ____________ HAVE YOU HAD AN OPERATION OR SERIOUS ILLNESS IN THE PAST 5 YEARS? ______ IF YES, PLEASE EXPLAIN: ______________________

LIST MEDICATION YOU ARE TAKING: ______________________________

ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATION OR PAIN KILLERS: ______________

IF YES, LIST: ______________________________

HAVE YOU BEEN TOLD TO TAKE ANTIBIOTIC BEFORE DENTAL TREATMENT? ______________

"MEDICAL HISTORY"

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? - INDICATE WITH A (☒)

- ________ Presently Pregnant - Month ____________
- ________ Diabetes
- ________ Kidney Problems
- ________ Liver Problems
- ________ Hepatitis/AIDS/Syphilis/Herpes/other STD's
- ________ Heart or Circulatory Problems
  - ________ Blood Thinners/Anticoagulant therapy (Coumadin)
  - ________ Angina/Coronary (Heart Attack)
  - ________ Heart Murmur/Mitral Valve Prolapse
  - ________ Prosthetic Valve Replacement/Other
  - ________ Congenital Heart Lesions
  - ________ Rheumatic fever
  - ________ High Blood Pressure (Hypertension)
- ________ Blood disorder/Anemia
- ________ Excessive Bleeding
- ________ Arthritis
- ________ Pains in arms/legs/chest
- ________ Shortness of breath
- ________ Fainting/dizzy spells
- ________ Psychiatric care
- ________ Tumor/cyst/malignancies
- ________ Radiation/Chemotherapy
- ________ Smoke Cigarettes/Cigars/Pipe
- ________ Vascular Disorders
- ________ Need to be pre-medicated for any reason
- ________ Ulcer/Colitis/Ileitis
- ________ Asthma/Hay fever/Allergies
- ________ Adverse Reaction to Anesthetics
- ________ Allergic to:
  - ______ Aspirin
  - ______ Latex
  - ______ Codeine
  - ______ Penicillin
  - ______ Sulfur
  - ______ Erythromycin
  - ______ Other ____________
- ________ Thyroid-Endocrine Disease
- ________ Tuberculosis
- ________ Do you have a persistent cough?
- ________ Do you cough up blood?
- ________ Ear/nose/sinus problems
- ________ Stroke
- ________ Swollen Joints
- ________ Difficulty breathing
- ________ Neurological problems
- ________ Emotional/Psychiatric problems
- ________ Systemic Lupus Erythematosus
- ________ Oral Contraceptives
- ________ Prosthetic Implant (Hip implant, etc)
- ________ Drug/Alcohol Dependency

IS THERE ANYTHING YOU THINK IMPORTANT FOR US TO KNOW? ______________________

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