PATIENT MEDICAL HISTORY

Date: _____

JOSEPH A. GASPARI, DMD
2591 Baglyos Circle, Suite C-41
Bethlehem, Pa 18020
484-821-2974

Pharmacy: _____

Pharmacy Phone: _____

Name	_____	Home Phone	(_____) _____ - _____
Street Address	_____	Business Phone	(_____) _____ - _____
City, ST ZIP	_____	Cell Phone	(_____) _____ - _____
Email Address	_____ @ _____	Sex	❑ Male ❑ Female
Date of Birth	____/____/____	Height ____ ' _____"	Weight _____
Occupation	_____	Social Security #	____ - ____ - ____
Employer	_____		
Marital Status	❑ Single ❑ Married	Spouse	_____
Closest Relative	_____	Phone	(_____) _____ - _____
Insurance Carrier	_____		
Physician Name	_____		
Address	_____		
	_____		
Phone	(_____) _____ - _____	Fax	(_____) _____ - _____

1. Have you had any serious illness or operation? (If so, please describe) ..... Yes No

   _____

2. Do you have or have you ever had any of the following diseases or problems?
   - a. Damaged heart valves or artificial valves ..... Yes No
   - b. Congenital heart disease ..... Yes No
   - c. Cardiovascular disease (heart attack, stroke, high BP, angina, MVP, murmur, pace maker, palpitations) ..... Yes No
   - d. Allergies, Sinus Trouble, Hay fever, Hives or Skin Rash (circle all that apply) ..... Yes No
   - e. Asthma ..... Yes No
     Type of inhaler used: _____ How often: _____
   - f. Fainting spells or Seizures ..... Yes No
   - g. Diabetes - Type 1 ❑ Type 2 ❑ ..... Yes No
   - h. Hepatitis, Jaundice, or Liver disease ..... Yes No
   - i. Arthritis ..... Yes No
   - j. Stomach Ulcers ..... Yes No
   - k. Kidney Trouble ..... Yes No
   - l. Tuberculosis ..... Yes No
   - m. Low Blood Pressure ..... Yes No
   - n. Epilepsy ..... Yes No
   - o. Psychiatric problems ..... Yes No
   - p. Cancer - Type: _____ Date: _____ ..... Yes No
   - q. AIDs or other immunosuppressive disorders ..... Yes No
   - r. Anemia ..... Yes No
   - s. Thyroid disorder ..... Yes No
   - t. Other _____

3. Do you need to pre-medicate for dental procedures ..... Yes No

4. Do you have implants placed anywhere in your body? (heart valve, hip, knee). ..... Yes No

5. Have you ever been diagnosed with osteoporosis and taken any bisphosphonates, i.e. Aredia, Zometa, Fosomax, Actonel, Boniva or any similar type medications? ..... Yes No

6. Have you had abnormal bleeding associated with previous surgery? ..... Yes No

7. Women - Are you pregnant or nursing ..... Yes No

Are you taking any of the following?

a. Antibiotics or Sulfa drugs ..... Yes No
b. Anticoagulants (blood thinners) ..... Yes No
c. Medicine for high blood pressure ..... Yes No
d. Cortisone (steroids) ..... Yes No
e. Tranquilizers (valium, etc.) ..... Yes No
f. Antihistamines ..... Yes No
g. Aspirin ..... Yes No
h. Insulin or similar drug ..... Yes No
i. Digitalis, Nitroglycerin or other heart medication ..... Yes No
j. Oral contraceptives or Hormonal Therapy ..... Yes No
k. OTC drugs or herbal supplements/vitamins ..... Yes No

8. Are you allergic or have you reacted adversely to:

a. Local anesthetics ..... Yes No
b. Penicillin or other antibiotics ..... Yes No
c. Sulfa drugs ..... Yes No
d. Barbiturates, sedatives, or sleeping pills ..... Yes No
e. Aspirin ..... Yes No
f. Iodine ..... Yes No
g. Codeine or other narcotics ..... Yes No
h. Latex ..... Yes No
i. Other _____

PLEASE LIST ALL OF YOUR MEDICATIONS AND DOSAGES:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL HISTORY UPDATES (to be completed at future visits)

Date: _____ Health Changes? No Yes _____ Medication Changes? No Yes _____ Patient Signature _____ Doctors Signature _____	Date: _____ Health Changes? No Yes _____ Medication Changes? No Yes _____ Patient Signature _____ Doctors Signature _____
Date: _____ Health Changes? No Yes _____ Medication Changes? No Yes _____ Patient Signature _____ Doctors Signature _____	Date: _____ Health Changes? No Yes _____ Medication Changes? No Yes _____ Patient Signature _____ Doctors Signature _____

_____ _____

Signature of Patient or Guardian (List relationship to patient) **Date**