

MEDICAL HISTORY FORM



RIOSECO FAMILY DENTISTRY

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Date _____ Social Security No. _____

Name _____

Phone () _____ () _____

Address _____

City _____ State _____ Zip _____

Date of birth _____ Height _____ Weight _____

Occupation _____

Marital status: married single divorced widowed

Name of Spouse _____ Closest relative _____ Phone () _____

If you are completing this form for another person, what is your relationship to that person? _____

How did you hear about us? _____

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during the initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? yes no

2. Has there been any change in your general health within the past year? yes no

3. My last physical examination was on _____

4. Are you now under the care of a physician? yes no
If so, what is the condition being treated?

5. The name and address of my physician(s) is:

6. Have you had any serious illness, or been hospitalized in the past 5 years? yes no
If so, what was the illness or problem?

7. Are you taking any medicine(s) including non-prescription medicine? yes no
If so, what medicine(s) are you taking?

8. Do you have or have you had any of the following diseases or problems?
a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease yes no
b. Cardiovascular disease, heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) yes no

1. Do you have chest pain upon exertion? yes no

2. Are you ever short of breath after mild exercise or when lying down? yes no

3. Do your ankles swell? yes no

4. Do you have inborn heart defects? yes no

5. Do you have a cardiac pacemaker? yes no

c. Allergy yes no

d. Sinus trouble yes no

e. Asthma or hay fever yes no

f. Fainting spells or seizures yes no

g. Persistent diarrhea of recent weight loss yes no

h. Diabetes yes no

i. Hepatitis, jaundice or liver disease yes no

j. AIDS or HIV infection yes no

k. Thyroid problems yes no

l. Respiratory problems, emphysema, bronchitis, etc. yes no

m. Arthritis or painful swollen joints yes no

n. Stomach ulcer or hyperacidity yes no

o. Kidney trouble yes no

p. Tuberculosis yes no

q. Persistent cough or cough that produces blood yes no

r. Persistent swollen glands in neck yes no

s. Low blood pressure yes no

t. Sexually transmitted disease yes no

(OVER)

- u. Epilepsy or other neurological disease yes no
- v. Problems with mental health yes no
- w. Cancer yes no
- x. Problems of the immune system yes no
9. Have you had abnormal bleeding? yes no
- a. Have you ever required a blood transfusion? yes no
10. Do you have any blood disorder such as anemia? yes no
11. Have you ever had any treatment for a tumor or growth? yes no
12. Are you allergic or have you had a reaction to:
- a. Local anesthetics yes no
- b. Penicillin or other antibiotic 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. Other: _____

13. Have you had any serious trouble associated with any previous treatment? yes no
 If so, explain: _____
14. Do you have any disease, condition, or problem not listed above that you think the doctor should know about? yes no
 If so, explain: _____
15. Are you wearing contact lenses? yes no
16. Are you wearing removable dental appliances? yes no

Women:

17. Are you pregnant? yes no
18. Do you have any problems associated with your menstrual period? yes no
 If so, explain: _____
19. Are you nursing? yes no
20. Are you taking birth control pills? yes no

Dental concerns:

21. Do you have any teeth that bother you? yes no
 If so, please check location with an "X":
- | | |
|-------------|------------|
| upper right | upper left |
| lower right | lower left |
22. Do you smoke? yes no
 If so, how much? _____
23. Do you or does your spouse/partner snore? yes no

24. Do your gums ever bleed? yes no
25. Do you use dental floss? yes no
26. Do you ever have pain in your mouth? yes no
27. Do you think you suffer from bad breath? yes no
28. Would you like to have whiter teeth? yes no
29. Would you like to have straighter teeth? yes no
30. My primary source of drinking water is: (please check one)
- Bottled Tap Filtered tap

Chief dental complaint: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of patient