

Joseph C. Ardizzone, D.D.S.  
30317 16th Avenue So  
Federal Way, WA 98003

**HEALTH HISTORY**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: M/F

What is the date of your last physical exam? \_\_\_\_\_ Physician's  
Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Are you currently under physician's care? \_\_\_\_\_  
If yes please explain: \_\_\_\_\_

Please Circle Yes or No:

- Have you ever had any problems associated with previous dental treatment? Yes No
- Do your gums bleed when brushing or flossing your teeth? Yes No
- Have you ever had a skin rash or other reaction to metal jewelry, or any known allergies to metals? Yes No
- Have you ever experienced any adverse reaction to dental anesthetic? Yes No
- Have you ever experienced any excessive bleeding requiring special treatment? Yes No
- Are you Allergic to any medications such as: Yes No  
Penicillin Codeine Aspirin Other

Do you or have you ever had any of the following conditions?  
Please circle Yes or No.

- Yes No Heart Trouble \_\_\_\_\_
- Yes No Heart Murmur \_\_\_\_\_
- Yes No Pains or tightness in chest \_\_\_\_\_
- Yes No Rheumatic Fever \_\_\_\_\_
- Yes No Congenital Heart Disease \_\_\_\_\_
- Yes No Liver disorders/Hepatitis Type \_\_\_\_\_
- Yes No Mononucleosis \_\_\_\_\_
- Yes No Jaundice \_\_\_\_\_
- Yes No Epilepsy \_\_\_\_\_
- Yes No Muscle tremors \_\_\_\_\_
- Yes No Accident of trauma to the head, neck or face \_\_\_\_\_
- Yes No Sinus problems \_\_\_\_\_
- Yes No Frequent headaches \_\_\_\_\_
- Yes No Allergies \_\_\_\_\_

(continued on next page)

Yes	No	Asthma	_____
Yes	No	Breathing problems	_____
Yes	No	Tuberculosis	_____
Yes	No	Diabetes	_____
Yes	No	Anemia	_____
Yes	No	Kidney Disease	_____
Yes	No	High blood pressure or low blood pressure	_____
Yes	No	Arteriosclerosis	_____
Yes	No	Stroke	_____
Yes	No	Arthritis	Type_____
Yes	No	HIV	_____
Yes	No	Cancer or Tumor	Type_____
Yes	No	Radiation Treatment	_____
Yes	No	Venereal Disease	_____
Yes	No	AIDS	_____
Yes	No	Alcohol use problems	_____
Yes	No	Drug use problems	_____
Yes	No	Psychological or Psychiatric care	_____
Yes	No	Artificial joints, valves or implants	_____
Yes	No	Hospitalization in the past ten years	_____
Yes	No	Operations	_____

For Women:

Yes	No	Are you currently pregnant?	_____
Yes	No	Endocrine or hormone problems	_____
Yes	No	Birth control	Type_____

Please list any other significant health problems we should know of:

\_\_\_\_\_  
\_\_\_\_\_.

Please list all medications you are currently taking. Please include dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_.

I hereby certify that the above information is true, accurate and complete to the best of my knowledge and I understand that failure to inform Dr. Ardizzone of any health conditions may result in improper diagnosis and/or unnecessary treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_