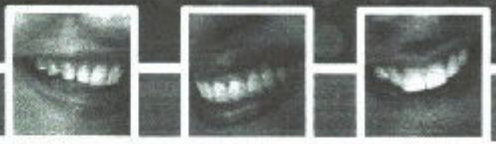
Michael G. Cattafesta D.D.S.,P.C.
2579 John Milton Dr. #350
CattafestaDDS@gmail.com
Herndon VA 20171
(703)620-4050



Medical/Dental History

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Medical History

Do you have a personal physician?

◯ Yes ◯ No

Physician's Name:

_____

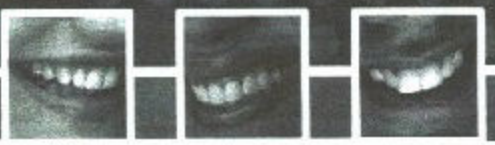
Phone #:

_____

Date of last visit:

_____

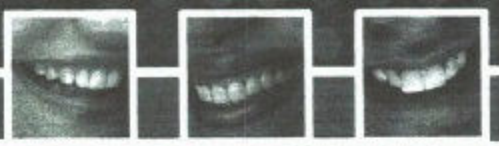
Michael G. Cattafesta D.D.S.,P.C.
2579 John Milton Dr. #350
CattafestaDDS@gmail.com
Herndon VA 20171
(703)620-4050



Your current physical health is:

◯ Good ◯ Fair ◯ Poor

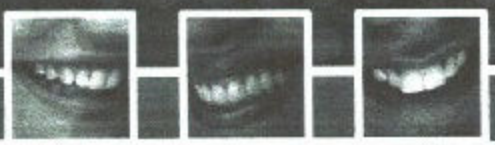
Michael G. Cattafesta D.D.S.,P.C.
2579 John Milton Dr. #350
CattafestaDDS@gmail.com
Herndon VA 20171
(703)620-4050



Have you ever had any of the following diseases or medical problems? (check all that apply)

- ☐ Acetaminophen Allerg
- ☐ Anesthetics reaction
- ☐ Arti. Bones/Joints
- ☐ Atherosclerosis
- ☐ Cancer/Chemotherapy
- ☐ CPAP/Sleep Apnea
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Fibromyalgia
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Latex Allergy
- ☐ Med for Osteoporosis
- ☐ Mouth Ulcers
- ☐ Pacemaker
- ☐ Premedication
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sulfa Allergy
- ☐ Thyroid Problems
- ☐ Tumors/Growths
- ☐ Alcohol/Drug Abuse
- ☐ Anxiety
- ☐ Aspirin Allergy
- ☐ Blood Disorder
- ☐ Cardiac Arrhythmia
- ☐ Delayed healing
- ☐ Diabetes
- ☐ Erythromycin Allergy
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ HIV+/AIDS
- ☐ Immunodeficiency
- ☐ Liver Problems
- ☐ Mental/Psychiatric
- ☐ Osteomyelitis
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stomach Prob/Colitis
- ☐ Taking Blood Thinner
- ☐ Tobacco Use
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Codeine Allergy
- ☐ Dental Ansth Allergy
- ☐ Difficulty Breathing
- ☐ Exces/Abnor Bleeding
- ☐ Heart Disease
- ☐ Herpes/Fever Blister
- ☐ HPV
- ☐ Kidney Disorders
- ☐ Lyme Disease
- ☐ Metal Allergy
- ☐ Osteonecrosis
- ☐ Penicillin Allergy
- ☐ Reflux/GERD
- ☐ Shingles
- ☐ Stroke
- ☐ Tetracycline Allergy
- ☐ Tuberculosis

Michael G. Cattafesta D.D.S.,P.C.
2579 John Milton Dr. #350
CattafestaDDS@gmail.com
Herndon VA 20171
(703)620-4050



Do you have any of the following chronic diseases/conditions? Check box for yes response.

☐ Back injuries or problems ☐ Parathyroid problems ☐ Lung disease

☐ Snoring ☐ Frequent headaches

Please list any other serious medical condition(s) that you have ever had:

Please list any other drugs/materials that you are allergic to:

Are you taking any prescription/over-the-counter or herbal supplement drugs?

◯ Yes ◯ No

Please list each one:

FOR WOMEN: Are you using a prescribed method of birth control?

◯ Yes ◯ No

Are you pregnant?

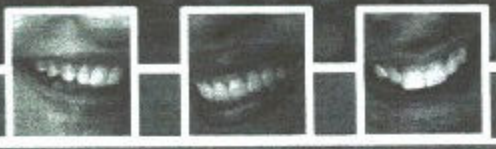
◯ Yes ◯ No

Week#:

Are you nursing?

◯ Yes ◯ No

Michael G. Cattafesta D.D.S.,P.C.
2579 John Milton Dr. #350
CattafestaDDS@gmail.com
Herndon VA 20171
(703)620-4050



Dental History

Do you require antbiotics before dental treatment?

◯ Yes ◯ No

Are you currently in pain?

◯ Yes ◯ No

Do your gums ever bleed?

◯ Yes ◯ No

Why have you come to the dentist today?

Do you wear a night guard?

◯ Yes ◯ No

Your current dental health is:

◯ Good ◯ Fair ◯ Poor

Do you like your smile?

◯ Yes ◯ No

Would you like whiter teeth?

◯ Yes ◯ No

Would you like fresher breath?

◯ Yes ◯ No

Michael G. Cattafesta D.D.S.,P.C.
2579 John Milton Dr. #350
CattafestaDDS@gmail.com
Herndon VA 20171
(703)620-4050

How many times a week do you floss?

How many times a day do you brush?

Type of toothbrush?

◯ Traditional ◯ Electric

Do you have a history of any of the following? Check box for yes response.

- ☐ TMJ
- ☐ Implants
- ☐ Gum Disease
- ☐ Anxiety related to dental procedures
- ☐ Orthodontics
- ☐ Dry Mouth
- ☐ Clenching or Grinding

Name of patient, parent or guardian completing this form:

Relationship to patient:

Response Date: