

Stephen M. Sgrazutti, D.D.S.

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SaginawFamilyDentistry.com



Medical History

Patient Name:
Last First MI Preferred Name

Physician's name

Date of Last Physical

Have you ever had any of the following? (check boxes that apply):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro |
| <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Fosomax | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Do you need to premedicated? (Artificial Joints, Heart Condition, Rheumatic Fever)

Yes No

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Do you have any drug allergies or have you ever had an adverse reaction to any medication?

Yes No

If yes, what

Are you taking any medications, please list

Are you under the care of a physician

Yes No

For what condition?

If patient is a child, what is his/her weight

(Woman) Do you suspect that you are pregnant?

Yes No

Are you nursing

Yes No

Is there anything else we should know about your medical history

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The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that may have made in the completion of this form

Signature: _____

Date:

Response Date: