



2809 COLTSGATE ROAD SUITE 210 CHARLOTTE, NC 28211
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FIRST NAME	LAST NAME	MIDDLE NAME
PHONE NUMBER	BIRTH	SOCIAL SECURITY (INSURANCE PURPOSES)
ADDRESS	CITY, STATE, ZIP CODE	OCCUPATION/EMPLOYER
GENERAL DENTIST NAME	DENTIST PHONE NUMBER/EMAIL	YOUR EMAIL

MEDICAL HISTORY

- | | | |
|--|---------|----|
| 1. DO YOU HAVE UNHEALED ORAL INJURIES, GROWTHS, OR SPOTS IN YOUR MOUTH? | 1. YES | NO |
| 2. HAS THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? | 2. YES | NO |
| 3. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR A CURRENT PROBLEM? | 3. YES | NO |
| 4. HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS? | 4. YES | NO |
| 5. HAVE YOU RECEIVED DRUG ADDICTION OR ALCOHOL THERAPY IN THE PAST 5 YEARS | 5. YES | NO |
| 6. HAVE YOU EVER HAD ALLERGIC OR ADVERSE REACTIONS TO MEDICATIONS? WHICH ONES? | 6. YES | NO |
| 7. IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? | 7. YES | NO |
| 8. DO YOU WISH TO SPEAK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING? | 8. YES | NO |
| 9. HAVE YOU HAD ABNORMAL BLEEDING WITH PREVIOUS EXTRACTIONS OR SURGERIES? | 9. YES | NO |
| 10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? | 10. YES | NO |
| 11. HAVE YOU EVER HAD SURGERY AND/OR RADIATION FOR A TUMOR, GROWTH, OR CONDITION? | 11. YES | NO |
| 12. HAVE YOU EVER TESTED POSITIVELY FOR HIV VIRUS OR AIDS? IF SO, STATE DATE AND DOCTOR. | 12. YES | NO |
| 13. ARE YOU REQUIRED TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT? Some conditions
Require this. | 13. YES | NO |
| 14. ARE YOU PREGNANT, NURSING OR ON BIRTH CONTROL? | 14. YES | NO |

15. HAVE YOU OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS
IF NONE, CHECK HERE

- | | |
|---------------------------|---------------------------|
| HIGH BLOOD PRESSURE | SINUS TROUBLE |
| HEART MURMUR | THYROID PROBLEMS |
| JOINT PROSTHESIS | DIABETES |
| RHEUMATIC FEVER | STOMACH ULCERS, COLITIS |
| CONGENITAL HEART DISEASE | HEPATITIS, LIVER DIS. |
| HEART DIS, ATTACK, STROKE | KIDNEY PROBLEMS |
| PROSTHETIC HEART VALVE | PSYCHIATRIC TREATMENT |
| BLOOD DISORDER | FAINTING, SEIZURES |
| VENEREAL DISEASE | EPILEPSY |
| ASTHMA | CANCER |
| ALLERGY TO LATEX | TMJ, JAW PAIN |
| LOW BLOOD PRESSURE | DIALYSIS |
| CHEST PAIN ANGINA | IRREG. HEARTBEAT |
| ARTHRITIS JOINT DIS. | CONTAGIOUS DISEASES |
| CARDIAC PACEMAKER | BRONCHITIS, CHRONIC COUGH |
| HEART SURGERY | HAY FEVER |
| DELEY IN HEALING | IMMUNE SYSTEM PROBLEMS |
| TUBERCULOSIS | DIFFICULTY BREATHING |
| EMPHYSEMA | CHRONIC FATIGUE |
| CHEMOTHERAPY | HISTORY OF DRUG ABUSE |
| ON A DIET | WEAR CONTACT LENSES |
| ALCOHOL ABUSE | BRUISE EASILY |
| EYE DIS. GLAUCOMS | GALLBLADDER TROUBLE |
| MONONUCLEOSIS | |

16 ARE YOU TAKING HERBAL MEDICATION (I.E. ST. JOHN'S WORT) **YES** **NO**

17. HAVE YOU EVER TAKEN THE "FEN-PHEN" DIET? **YES** **NO**

18. DO YOU HAVE ANY CONDITION OR DISEASES NOT LISTED ABOVE? IF YES LIST THEM BELOW

19. ARE YOU TAKING ANY MEDICATION OR DRUGS? PLEASE LIST BELOW.

ARE YOU ALLERGIC TO ANYTHING?

SIGNATURE

DATE