CAROLINA DENTISTRY @ THE STATELINE

MEDICAL HISTORY

Patient Name: Birth Date: Date Created:

Question	Answer	If yes
Are you presently, or have you been under the care of a physician during the past year?	Yes No	If yes
Are you taking any medications, or drugs (Prescribed, over-the-counter, or recreational)?	Yes No	If yes
Have you ever had a reaction to local anesthetic (Novocain, Lidocaine)?	Yes No	If yes
Have you ever experienced any complications or illness following dental treatment?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Have you ever had instances of prolonged or unusual bleeding? Do you bruise easily?	Yes No	If yes
Do you use tobacco?	Yes No	If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Taking oral contraceptives?
- ☐ Nursing

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Metals, Nickel, etc
- ☐ Latex
- ☐ Sulfa Drugs

Allergic to other drugs/medications or materials? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
Heart Condition	Yes No	Lung Disease	Yes No	TB (Tuberculosis)	Yes No	Glaucoma	Yes No
Congenital Heart Disorder	Yes No	Asthma	Yes No	Kidney Disease	Yes No	Veneral Disease	Yes No
Heart Surgery	Yes No	Liver Disease	Yes No	Thyroid Disease	Yes No	AIDS / HIV Postive	Yes No
High Blood Pressure	Yes No	Jaundice	Yes No	Hip, Knee, Joint Replaced	Yes No	Blood Disorders, Hemophila	Yes No
Heart Pacemaker	Yes No	Hepatitis	Yes No	Cancer	Yes No	Blood Transfusion	Yes No
Angina	Yes No	Diabetes	Yes No	Radiation Therapy	Yes No	Convulsions, Seizures	Yes No
Frequent Chest Pains	Yes No	Hypoglycemia	Yes No	Osteoporosis	Yes No	Fainting Spells, Dizzines	Yes No
Shortness of Breath	Yes No	Sinus Trouble / Hayfever	Yes No	Crohn's Disease	Yes No	Alzheimer's Disease	Yes No
Stroke	Yes No	Cold Sores/Fever Blisters	Yes No	Pain in Jaw Joint	Yes No	Psychiatric Care	Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________