3725 Wrightsville Ave., Suite A • Wilmington, NC 28403
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Today's date: ___/___/___

Patient Name: ______________________________ **Birthdate:** ___/___/___

Name of person completing form (if different from patient) and relation to patient: ______________________________

Please answer the following questions to the best of your ability, realizing that true accurate answers are important to providing appropriate quality care. All information will be kept confidential in compliance with all HIPPA laws/regulations.

*Please answer by circling Y (Yes) or N (No), or checking the boxes that apply to you for each question.

1. Are you in good health? .... Y.....N
2. Has there been any change in your general health in the past year? .... Y.....N
3. Date of your last check up by a physician? ___/___/___ Physicians Name: ______________________________
4. Are you currently under a physicians care? .... Y.....N
   If so, what for? ______________________________
5. Have you had any serious illness, operation, or hospitalization? .... Y.....N
   If so, describe and give approximate date: ______________________________
6. Have you ever had intravenous sedation or general anesthesia? .... Y.....N
   Describe any adverse effects. ______________________________
7. Do you generally tolerate dental treatment well? .... Y.....N
8. DO YOU HAVE OR HAVE YOU EVER HAD:
   a) Heart disease diagnosed at birth? .... Y.....N
   b) Rheumatic fever or rheumatic heart disease? .... Y.....N
   c) Any of the following cardiovascular diseases:
      ❏ Chest pains ❏ Heart trouble ❏ Heart attack ❏ Coronary artery disease
      ❏ High blood pressure ❏ Stroke ❏ Heart palpitations ❏ Heart surgery
      ❏ Angioplasty ❏ Pacemaker
   d) Any of the following lung diseases:
      ❏ Asthma ❏ Emphysema ❏ Chronic cough ❏ Bronchitis
      ❏ TB (tuberculosis) ❏ Shortness of breath ❏ Severe cough ❏ Pneumonia
   e) Any of the following neurological disorders:
      ❏ Seizure ❏ Epilepsy ❏ Fainting ❏ Dizziness ❏ Nervous disorder
   f) Any of the following blood diseases:
      ❏ Bleeding disorder ❏ Anemia ❏ Blood transfusion ❏ Do you bruise easily
   g) Any of the following liver diseases:
      ❏ Jaundice ❏ Hepatitis A ❏ Hepatitis B ❏ Hepatitis C ❏ Hepatitis D
   h) Kidney disease? .... Y.....N
   i) Diabetes? .... Y.....N
   j) Thyroid disease? .... Y.....N
   k) Arthritis? .... Y.....N
      If so, which joints are affected? ______________________________

l) Stomach ulcers or intestinal problems? .... Y.....N
m) Glaucoma? .... Y.....N
n) Frequent or recurring mouth sores? .... Y.....N
o) Implants or artificial joints anywhere in your body? .... Y.....N
❏ Heart valve ❏ Knee ❏ Hip Other? ________________
p) Radiation treatment of the head or neck region? .... Y.....N
q) Any of the following problems with your jaw joint:
❏ Noises in jaw joint ❏ Pain near ear when chewing ❏ Do you grind your teeth? ❏ Do you clench your teeth?
r) Sinus or nasal problems? .... Y.....N
s) Any disease, drug or transplant operation that has depressed your immune system? .... Y.....N
t) Recurrent infections of any kind? .... Y.....N
u) Parkinson's disease or tremors? .... Y.....N
v) Are you taking Fosamax or other drug for osteoporosis or other bone disorder? .... Y.....N

9. ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

❏ Antibiotics ❏ Anticoagulants (Blood Thinner) ❏ Thyroid medication
❏ Heart medications ❏ High blood pressure ❏ Antihistamines/decongestants
❏ Steroids ❏ Antidepressants/tranquilizers ❏ Antacids (stomach/GI medications)
❏ Cholesterol drugs ❏ Anti-inflammatory drug ❏ Narcotics
❏ Aspirin ❏ Pain relievers ❏ Vitamins/Supplements
❏ "Recreational" Drugs (marijuana, cocaine or other)
❏ Any other regular medications, over the counter pill or supplements? ________________

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PLEASE LIST ALL CURRENT MEDICATIONS HERE: ________________

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10. Are you allergic to or had a bad reaction from:

❏ Local anesthetic (Novocain-like drugs) ❏ Penicillin/Amoxicillin/Cephalosporins (other antibiotics)
❏ Barbiturates/Sedatives ❏ Aspirin/Ibuprofen/NSAIDS (other pain relievers)
❏ Codeine or other narcotics or opioids ❏ Latex
❏ Nitrous oxide (laughing gas)
Have you had any other allergies or allergic reactions? ________________

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11. Do you have hay fever, frequent skin rashes, etc.? .... Y.....N
12. Do you drink alcohol? How much? .... Y.....N
13. Do you use tobacco products? .... Y.....N
What type? ____________ How much? ____________ For how long? ____________
14. Are you, or have you ever been in a drug or alcohol recovery program? .... Y.....N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?

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16. Do you have any mental or psychiatric problems? .... Y.....N
17. Do you wish to talk to the doctor privately about anything? .... Y.....N
18. **WOMEN**
a) Are you taking birth control pills? .... Y.....N
b) Are you pregnant, trying to become pregnant or any chance you might be pregnant? .... Y.....N
c) Are you breast feeding? .... Y.....N
d) Are you taking hormonal replacement? .... Y.....N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature ________________________ Date___/___/___

*If you have had a change in Address or Phone Number please provide the new information below.

Address: ________________ City/State/Zip: ________________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________