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Telephone (910) 762-0786

PRINT NAME: _____

MEDICAL HISTORY

___ Yes ___ No Are you under medical treatment now?
For what? _____

___ Yes ___ No Have you had any major operations?
List: _____
_____

___ Yes ___ No Have you ever had a serious accident involving your head or neck? _____

___ Yes ___ No Have any wounds healed slowly or presented other complications? _____

___ Yes ___ No Are you pregnant? Due Date: _____

___ Yes ___ No Are you allergic to any medicines? List: _____

Have you ever had any of the following (check if yes) :

__ Heart ailment
__ Heart murmur
__ High blood pressure
__ Low blood pressure
__ Respiratory disease
__ Diabetes
__ Rheumatic fever
__ Rheumatism or arthritis
__ Cancer
__ Pacemaker
__ Donor organs
__ Any blood disease
__ Any liver diesase
__ Any kidney disease
__ Any stomach or intestinal disease
__ Hepatitis or jaundice
__ Epilepsy
__ HIV or AIDS
__ Artificial joints
__ Prosthetic heart valves, vessels
__ Fainting episodes
__ Blood transfusions

___ Yes ___ No Are you taking drugs or medications?

| Medicine | Reason |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

DENTAL HISTORY

___ Yes ___ No Have you had recent dental x-rays? When: _____

___ Yes ___ No Is any part of your mouth hurting at this time?

___ Yes ___ No Do your gums bleed?

___ Yes ___ No Do you use tobacco?

___Yes ___ No Have you ever had dental anesthetic?

___ Yes ___ No Any reactions or allergic symptoms to dental materials?

___ Yes ___ No Any difficulties with past extractions?

___ Yes ___ No Any concerns about your teeth?

_____ Date of last dental visit.

Signature: _____ Date: _____