Suite 210, AdBel Plaza
1401 Matthews Township Parkway
Matthews, NC 28105
(704) 844-0014

HEALTH HISTORY

Name:_____Date:_____

Reason for Appointment:_____

Previous Dentist's Name/Address/Phone	Physician's Name/Address/Phone

Answers to the questions below will help the dentist decide how to best treat your dental problems. If you don't know the answer to a question, please leave it blank. If you need help in completing the form, please tell the receptionist.

Dental History

1. When was your last dental check up? _____
2. When were your teeth last cleaned? _____
3. When were your last dental x-rays taken? _____
4. Have you had missing teeth replaced by bridgework or dentures? …… Yes No
5. Are you happy with the appearance of your teeth? …… Yes No
6. Do you have any apprehensions (fears) related to dental treatment? …… Yes No
7. Have you ever bled excessively after a tooth extraction? ……. Yes No
8. What did you dislike most about your previous dental experience? _____
   _____
9. What did you like most about your previous dental experience? _____
   _____

Medical History

10. Have there been any changes in your health within the past year? …… Yes No
    If yes, explain_____
11. Have you had treatment by a physician within the past year? …….. Yes No
    If yes, explain_____
12. Have you ever had major surgery or been hospitalized for any reason? …….. Yes No
    If yes, explain_____
13. Are you currently taking any medication (birth control pills included)? …….. Yes No
    If yes, explain_____
14. Are there any medications that make you sick or ill? …… Yes No
    If yes, explain_____
15. Are you allergic to anything? ……. Yes No
    If yes, explain_____
16. (Women) a. Is it possible you are pregnant? If yes, what is the due date? _____ Yes No
    b. Do you have any problems associated with your period? …… Yes No

(over)

Do you have, or have you ever had any of the following:

17.	Hepatitis…….	Yes	No
18.	Jaundice, other liver disorder…….	Yes	No
19.	Blood transfusions…….	Yes	No
20.	Refusal for blood transfusion…….	Yes	No
21.	AIDS; carrier of AIDS virus……..	Yes	No
22.	Hemophilia; bleeding disorder……	Yes	No
23.	Prolonged bleeding from a cut, injury or surgery……	Yes	No
24.	Venereal disease…….	Yes	No
25.	Oral ulcers or sores……	Yes	No
26.	Tuberculosis……...	Yes	No
27.	Positive TB test……...	Yes	No
28.	Shortness of breath with normal activity…	Yes	No
29.	Asthma……	Yes	No
30.	Anemia; low or thin blood…….	Yes	No
31.	Kidney or bladder disorder…….	Yes	No
32.	Sugar diabetes…….	Yes	No
33.	Thyroid disorder…….	Yes	No
34.	Fainting spells or blackouts……	Yes	No
35.	Seizures, convulsions or epilepsy……..	Yes	No
36.	Stomach or intestinal ulcers……	Yes	No
37.	Rheumatic fever…….	Yes	No
38.	Congenital heart defect……..	Yes	No
39.	Heart murmur…….	Yes	No
40.	Heart attack……	Yes	No
41.	Angina; severe chest pain……...	Yes	No
42.	Heart surgery……..	Yes	No
43.	Cardiac pacemaker…….	Yes	No
44.	Other heart disease…….	Yes	No
45.	High blood pressure……	Yes	No
46.	Low blood pressure……	Yes	No
47.	Stroke…….	Yes	No
48.	Tumor or cancer…….	Yes	No
49.	Radiation or Xray treatments…….	Yes	No
50.	Artificial limb, joint, heart valve or prosthesis……	Yes	No
51.	Organ transplant…….	Yes	No
52.	Bone, joint or muscle problems…….	Yes	No
53.	Visual problems…….	Yes	No
54.	Hearing problems……...	Yes	No
55.	Emotional problems……	Yes	No
56.	Alcohol abuse…….	Yes	No
57.	Drug abuse……..	Yes	No
58.	Use of tobacco products…….	Yes	No
59.	Other_____	Yes	No

To the best of my knowledge, the foregoing questions have been accurately answered. During treatment, I will report any changes in my health, illnesses, hospitalizations, or changes in medications.

_____ _____
Signature of patient or guardian Date

……...

For Dentist's use only

Vital statistics: BP _____ Pulse _____ Temp_____ Weight_____

_____ _____
Dentist's Signature Date