MERCE Family Healthcare

Medical Center: 1831 North Fayetteville Street • Asheboro, NC 27203
Phone: 336-672-1300 / Fax: 336-672-3044

Dental Center: 308 Brewer Street • Asheboro, NC 27203
Phone: 336-610-7000 / Fax: 336-610-7003

PATIENT HISTORY - Please Print

Patient Name: _____ MR#: _____ Date: _____

Are you under a physician's care? _____ Yes _____ No If yes, explain: _____
Are you currently taking any medication? If yes, list: _____
Are you currently taking any herbal medication or vitamins? _____ Yes _____ No
When was your last tetanus shot? _____
When was your last complete medical examination? _____
Are you on a special diet? _____ Yes _____ No
Do you use tobacco? _____ Yes _____ No
Do you use controlled substances? _____ Yes _____ No

Have you ever:

Been hospitalized? _____ Yes _____ No If yes, explain: _____
Been exposed to asbestos, chemical dust or loud noises? _____ Yes _____ No Which one: _____
Had a serious head or neck injury? _____ Yes _____ No
Taken Phen-Fen or Redux? _____ Yes _____ No
Used tobacco? _____ Yes _____ No How often: _____
Used alcohol? _____ Yes _____ No
Used controlled substances? _____ Yes _____ No

Women only:

Are you pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?
Female Problems? _____ Yes _____ No List: _____
Pregnancies _____ Deliveries _____ # Miscarriages/Abortions _____

Allergies:

Are you allergic to any of the following:
_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____ Latex _____ Local Anesthetics
Other, Please list

Behavioral Health History:

Have you ever:

Been diagnosed with a mental health disorder? _____ Yes _____ No
Been diagnosed with a substance abuse disorder? _____ Yes _____ No
Been hospitalized in a psychiatric facility? _____ Yes _____ No If yes, explain: _____
Been in detox? _____ Yes _____ No If yes, explain: _____
Been seen by a mental health professional? _____ Yes _____ No If yes, explain: _____
Been seen by a substance use professional? _____ Yes _____ No If yes, explain: _____
Been involved in any legal charges? _____ Yes _____ No If yes, explain: _____
Had thoughts to harm yourself or others? _____ Yes _____ No If yes, explain: _____

Do you have any of the following symptoms? : (Check all that apply)

__Binging/Purging
__Difficulty falling asleep
__Difficulty waking up
__Excessive eating
__High energy/mania
__Low energy/fatigue
__Nightmares
__Poor appetite
__Weight gain/loss
__ Crying spells (frequency): _____
__Depressed/low mood
__ Decreased Interest
__ Excessive/Inappropriate Guilt
__ Hopeless/Helpless
__ Irritability
__ Isolates from others/Socially withdrawn
__ Poor daily activities (ADLs)
__ Postpartum
__Avoidance
__Excessive worry
__Heart pounds for no apparent reason
__Panic attacks (frequency): _____
__Phobias: _____
__Shortness of breath
__Trembling/Shaking
__Unexplained dizziness
__Easily distracted
__Fidgety
__Forgetful
__Flashbacks
__Hair pulling
__Hoarding
__Intrusive thoughts
__Skin picking

Dental Patients Only: Please mark if any of the following pertain to you:

__ Abscess in mouth	__ Bite nails/objects	__ Chew tobacco	__ Gag easily	__ Pain around ears
__ Any food traps	__ Bleeding gums	__ Grinding teeth	__ Infection in gums	__ Sensitive gums
__ Bad breath	__ Blisters	__ Difficulty chewing	__ Loose teeth	__ Sensitive hot/cold
__ Bad taste	__ Chew on one side	__ Dry mouth	__ Missing teeth	__ Stained teeth

COMMENTS: _____

Medical History:

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

__ Abnormal Pap	__AIDS/HIV Positive	__Alzheimer's Disease	__Anaphylaxis	__Angina
__Arthritis/Gout	__Artificial Heart Valve	__Artificial Joint	__Asthma	__Blood Disease
__Blood Transfusion	__Breathing Problem	__Bruise Easily	__Cancer	__Chemotherapy
__Chest Pains	__Cold Sores/Blisters	__Congenital Heart Disorder	__Convulsions	__Cortisone Medicine
__Diabetes	__Easily Winded	__Endocarditis	__Emphysema	__Epilepsy or Seizures
__Excessive Bleeding	__Fainting Spells/Dizziness	__Frequent Cough	__Frequent Diarrhea	__Frequent Headaches
__Gall Stones/Gall Bladder	__Glaucoma	__Hay Fever (Allergies)	__Heart Attack/Failure	__Heart Murmur
__Heart Pace Maker	__Heart Trouble/Disease	__Hemophilia	__Hepatitis A	__Hepatitis B or C
__High Blood Pressure	__High Cholesterol	__Hives or Rash	__Hypoglycemia	__Irregular Heartbeat
__Kidney/Bladder Problems	__Leukemia	__Liver Disease	__Lung Disease	__Male Problems
__Mitral Valve Prolapse	__Pain in Jaw Joints	__Osteoporosis	__Overuse of Drugs/Alcohol	__Parathyroid Disease
__Psychiatric Care	__Radiation Treatments	__Recent Weight Loss	__Renal Dialysis	__Rheumatic Fever
__Rheumatism	__Scarlet Fever	__Shingles	__Sickle Cell Disease	__Sinus Trouble
__Spina Bifida	__Skin Problems	__Stomach/Intestinal Disease	__Stroke	__Swelling of Limbs
__Thyroid Disease	__Tonsillitis	__Tuberculosis	__Tumors or Growths	__Ulcers
__Venereal Disease (STD)	__Yellow Jaundice			

Other (describe): _____

Family History: List all medical conditions in your family:

Father: _____
Mother: _____
Paternal Grandfather: _____
Paternal Grandmother: _____
Maternal Grandfather: _____
Maternal grandmother: _____
Brothers/Sisters: _____
Children: _____
_____

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 medical and/or dental office of any changes in my medical status.

Patient Signature: _____ Date _____

Responsible Party's Signature: _____ Date _____