



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

MEDICAL 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 _____

Medical History:

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

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Cold Sores/Blisters | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cortisone Medicine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Gall Stones/Gall Bladder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever (Allergies) | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Male Problems |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Overuse of Drugs/Alcohol | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease (STD) | <input type="checkbox"/> Yellow Jaundice | | | |

Other (describe): _____

Allergies:

Are you allergic to any of the following:

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other, Please list _____

Family History: List all medical conditions in your family:

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

Dental Patients Only:

Please mark if any of the following pertain to you:

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Abscess in mouth | <input type="checkbox"/> Bite nails/objects | <input type="checkbox"/> Chew tobacco | <input type="checkbox"/> Gag easily | <input type="checkbox"/> Pain around ears |
| <input type="checkbox"/> Any food traps | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Infection in gums | <input type="checkbox"/> Sensitive gums |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Blisters | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitive hot/cold |
| <input type="checkbox"/> Bad taste | <input type="checkbox"/> Chew on one side | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Stained teeth |

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

Patient Signature: _____ Date _____

Responsible Party's Signature: _____ Date _____