Charlotte ProgressiveDentistry
Cosmetic • Family • Implant Dentistry

MEDICAL HISTORY

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Cell: (____) _____ Work: (____) _____

Date of Birth: _____ SSN: _____ E-mail _____

Emergency Contact: _____ Relationship: _____ Phone #: (___) _____

Complete with the Appropriate Answer:

1. How is your general health? □ Excellent □ Good □ Fair □ Poor Blood Pressure_____
2. Has there been a change in your health within the last year? □ Yes □ No
   If YES, please explain: _____
3. Have you been hospitalized for any reason in the last 5 years? □ Yes □ No
   If YES, please explain_____
4. Are you under the care of a physician? □ Yes □ No
   If YES, for what purpose? _____
   Physician's Name _____ Phone # _____ Date of last Medical Exam _____
5. Do you use **TOBACCO** in any form? □ Yes □ No Packs/Day? _____
6. Do you consume **ALCOHOL**? □ Yes □ No Drinks/Day? _____
7. Do you use any **RECREATIONAL DRUGS**? □ Yes □ No Please Describe: _____
8. Are you required to take **ANTIBIOTICS** prior to dental treatment? □ Yes □ No
9. Do you take **FOSAMAX, ACTONEL, or any medication for OSTEOPOROSIS (stronger bones)**? □ Yes □ No
10. Have you had problems with prior Dental Treatments? □ Yes □ No _____
11. Date of last Dental Exam and reason for visit: _____
12. Are you in **PAIN**? □ Yes □ No Please Describe: _____
13. Are you happy with the appearance of your teeth/gums/smile? □ Yes □ No
14. What don't you like about your smile? _____
15. Would you like to discuss enhancing the appearance of your smile? □ Yes □ No
16. Would you like to discuss how to make your teeth WHITE? □ Yes □ No

For Women Only

Are you PREGNANT? □ Yes □ No Are you taking ORAL CONTRACEPTIVES? □ Yes □ No

How many weeks? _____ Are you NURSING? □ Yes □ No

Patient Name: _____

Do You Have or Have You Ever Had Any of the Following?

YES	NO		YES	NO	
□	□	Heart Problems	□	□	Reaction to Local Anesthetic
□	□	Heart Attack/Heart Defect	□	□	Fainting Spells/Dizziness
□	□	Heart Murmur	□	□	Epilepsy/Seizures
□	□	Stroke/Hardening of Arteries	□	□	Asthma
□	□	High Blood Pressure	□	□	Shortness of Breath
□	□	Pacemaker/Defibrillator	□	□	Cancer/Tumors
□	□	Mitral Valve Prolapse/Heart Murmur	□	□	Radiation/Chemotherapy
□	□	Heart Bypass Surgery	□	□	Diabetes; __Type I __Type II
□	□	Artificial Heart Valve	□	□	Swollen Ankles
□	□	Chest Pain (Angina)	□	□	Tuberculosis
□	□	Bleeding/Clotting Problem	□	□	Blood Disease
□	□	Blood Transfusion; Date: _____	□	□	HIV/AIDS/ARC (Please Specify)
□	□	Anemia	□	□	Venereal Disease (Syphilis, Gonorrhea)
□	□	Liver Problems/Hepatitis A, B, or C (Specify)	□	□	Herpes
□	□	Jaundice	□	□	Dry Mouth
□	□	High Cholesterol	□	□	Sinusitis
□	□	Thyroid Disease	□	□	Stomach Ulcers
□	□	Kidney/Bladder Disease	□	□	Psychological/Psychiatric Disorder
□	□	Artificial Joint (Hip, Knee, Shoulder, etc.)	□	□	Other_____

Do you have an ALLERGY to any of the following?

YES	NO		YES	NO	
□	□	LATEX Allergy	□	□	Metals
□	□	Local Anesthetics	□	□	Iodine
□	□	Penicillin or other antibiotics	□	□	Hay fever/Seasonal
□	□	Sulfa Drugs	□	□	Animals
□	□	Codeine or other narcotics	□	□	Food
□	□	Barbiturates, sedatives, or sleeping pills	□	□	Other _____
□	□	Aspirin			

Medications

Please list any prescription or over-the-counter medications that you are taking:

_____

_____

_____

Do you have or have you ever had any other disease or medical problem **NOT** listed? □ Yes □ No

If YES, please explain: _____

Please Sign and Date

To the best of my knowledge, I have answered every question truthfully, completely and accurately. I will inform my dentist of any changes in my health and/or medication(s).

_____
Patient/Parent/Guardian Signature

_____
Date