FLETCHER FAMILY DENTISTRY

FletcherFamilyDentistry.com
info@fletcherfamilydentistry.com
PO Box 2139 | 235 Saint John Rd, Ste 110 • Fletcher, NC 28732
(828)654-7450

Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following question.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ Allergies
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Heart Val
- ☐ Bruise/ Bleed Easily
- ☐ Congenital Heart
- ☐ Epilepsy/ Seizures
- ☐ Hay Fever
- ☐ Hepatitis A, B, C
- ☐ Liver Disease
- ☐ Organ Transplant
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Stomach Issues
- ☐ Tobacco Use
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Diabetes
- ☐ Fainting/ Dizziness
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Mental Disorders
- ☐ Osteoporosis Med(s)
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ *Pre-Med - Other
- ☐ Allergy - Clind
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Asthma
- ☐ Chemotherapy
- ☐ Dry Mouth
- ☐ Fibromyalgia
- ☐ Heart Problem/Murmur
- ☐ Jaundice
- ☐ Mitral Valve Pro
- ☐ Other
- ☐ Pregnancy
- ☐ Sickle Cell Anemia
- ☐ Substance Abuse
- ☐ Venereal Disease
- ☐ AIDS/HIV+
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Chest Pain/Angina
- ☐ Emphysema/Bronchitis
- ☐ Growths
- ☐ Heart Surgery
- ☐ Kidney Problems
- ☐ Nervousness/Anxious
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Sinus Problems
- ☐ Thyroid Disease

- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking oral contraceptives
- ☐ FEMALE: Pregnant or Trying
- ☐ FEMALE: Nursing
- ☐ Use of controlled substances
- ☐ Special Diet
- ☐ Take or have taken: Phen-Fen or Redux
- ☐ Taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. 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. There are no other medical conditions or medications/allergies that have not been listed. It is my responsibility to inform the dental office of any changes in medical status. This will serve as my electronic signature.**

Signature _____ **Date** _____

Response Date: ____/____/_____