

DENTAL ACCESS CAROLINA—PATIENT'S MEDICAL INFORMATION

Name _____ Birthdate (mm/dd/yy) ____/____/____

Sex ____ Height ____ Weight ____ Race (Circle One) White Black Hispanic Other _____

Name of Physician _____ Phone _____ Last Seen _____

Date of Last Dental Visit _____ Name of Dentist _____ City _____

PATIENT'S MEDICAL INFORMATION

Yes No

____ Have you been seriously ill in the last 5 years? If yes, explain: _____

____ Have you ever been hospitalized or had a serious illness? If yes, explain: _____

____ Has a doctor told you to take antibiotics before ALL dental treatments?

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Yes No

____ Antibiotics (Penicillin, etc.)

____ Anticoagulants (blood thinners)

____ Antihistamine (Benadryl, etc.)

____ Aspirin (Advil, Nuprin, etc.)

____ Cortisone (Steroids)

____ Digitalis (Heart Medicine)

Yes No

____ Insulin (Diabetes Medication)

____ High Blood Pressure Medications

____ Nitroglycerine

____ Sulfa Drugs

____ Tranquilizers

____ Other, Please list _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO?

Yes No

____ Antibiotics (Penicillin, etc.)

____ Barbituates (Sleeping pills)

____ Sulfa Drugs

Yes No

____ Local Anesthetics

____ Narcotics (Codeine, etc.)

____ Other, Please list _____

Yes No

____ Latex

____ Red Dye

DO YOU HAVE OR HAVE YOU HAD?

Yes No

____ AIDS/HIV Positive

____ Chemotherapy

____ Bleeding Problems

____ Anemia

____ Sugar Diabetes

____ Heart Trouble or Murmur

____ Hives

____ Frequent Headaches

____ Stroke

____ Thyroid Disease

____ Venereal Disease

Yes No

____ Asthma/Hay Fever

____ Allergies

____ Cortisone/Steroids

____ Cancer or Tumor

____ Drug Addiction

____ Hepatitis-Jaundice

____ Prosthetic Hip/Heart Valve

____ Liver Disease

____ Rheumatic Fever/Rheumatic Heart Disease

____ Radiation for Head/Neck Cancer

____ Tuberculosis/Lung Disease

Yes (Si) No

____ Drug Interactions

____ Epilepsy Seizures

____ Frequent Fainting

____ Shortness of Breath

____ Head Injury

____ Kidney Disease

____ Psychological Problems

____ Sinus Trouble

Do you have any other medical condition(s) that we should know about? If so, please explain: _____
