MEDICAL HISTORY

919-859-1000 | email to: team@dentistrybydesignofcary.com

DENTISTRY by DESIGN of Cary
Evidence-Based Medicine

Date:		Patient's Name:		Date of Birth:	
Primary Care Physician:				Telephone:	
Medical Specialist(s):				Telephone:	
Pharmacy Name & Location:				Telephone:	

PLEASE CHECK MARKER IN ALL AREAS THAT APPLY

1. **Do you require an antibiotic premedication before dental work?**

☐ NO ☐ YES ☐ NOT SURE

If yes, for what condition? _____

If yes, what medication and dosage? _____

If yes, list prescribing Doctor, phone number? _____

2. **Do you have (or have you ever have been told you had) any of the following conditions?**
(Check mark all that apply)

Congenital heart problems	☐ NO	☐ YES	☐ NOT SURE
Infective Endocarditis or other heart infection	☐ NO	☐ YES	☐ NOT SURE
Artificial heart valves	☐ NO	☐ YES	☐ NOT SURE
Heart transplant	☐ NO	☐ YES	☐ NOT SURE
Artificial joints or prostheses	☐ NO	☐ YES	☐ NOT SURE

3. **Do you have any Allergies to Medication, Man Made or Environmental Substances including any of the following?**
If yes, what reaction(s) did you have to this substance? (Check mark all that apply, or note below)

ALLERGIES

Penicillin	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain):
Sulfa or other antibiotics	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain):
Codeine or Morphine	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain):
Dental anesthetic (e.g. Novocain, lidocaine)	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain):
Latex	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain):
Airborne Substances (e.g. pollen, perfume)	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain)
Aspirin	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain)
Other Medications or substances (explain)	NO ☐	YES ☐	☐ Rash ☐ Breathing problem ☐ Itching	☐ Stomach ☐ Intestinal	Other reaction(explain)

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4. Do you have, or have you ever been told you had any of the following conditions?

Please Check Each Condition either **NO, Yes, or Not Sure** that you have Currently or Previously AND

Please Click on button for Level of Control over Each Condition either **Poor / Good / Working On It**

CURRENT OR PREVIOUS MEDICAL CONDITIONS

		NO	YES	NOT SURE			NO	YES	NOT SURE
1	**Blood disorders** (e.g. anemia, hemophilia, using blood thinning medicines) ☐ poor ☐ good ☐ working on it	☐	☐	☐	2	**Inflammatory diseases** (e.g. arthritis, rheumatism, lupus, fibromyalgia) ☐ poor ☐ good ☐ working on it	☐	☐	☐
3	**Heart disease** (e.g. angina, coronary artery disease, congestive heart failure) ☐ poor ☐ good ☐ working on it	☐	☐	☐	4	**Phobias, sever anxieties, depression or other psychological problems** ☐ poor ☐ good ☐ working on it	☐	☐	☐
5	Radiation, surgery, or chemotherapy to treat cancer list type & date ☐ poor ☐ good ☐ working on it	☐	☐	☐	6	**Diabetes** (sugar disease, blood sugar problems) ☐ poor ☐ good ☐ working on it	☐	☐	☐
7	**High blood pressure** (hypertension) ☐ poor ☐ good ☐ working on it	☐	☐	☐	8	**Asthma, emphysema, or other lung disease** ☐ poor ☐ good ☐ working on it	☐	☐	☐
9	**Bleed excessively** after being cut or receiving dental care ☐ poor ☐ good ☐ working on it	☐	☐	☐	10	**Stomach or intestinal problems** (e.g. GERD, acid reflux) ☐ poor ☐ good ☐ working on it	☐	☐	☐
11	**Heart attack, stroke or coronary bypass operation** ☐ poor ☐ good ☐ working on it	☐	☐	☐	12	**Shortness of breath after climbing 1 flight of stairs** ☐ poor ☐ good ☐ working on it	☐	☐	☐
13	**Frequent headaches** ☐ poor ☐ good ☐ working on it	☐	☐	☐	14	**High cholesterol** ☐ poor ☐ good ☐ working on it	☐	☐	☐
15	**Thyroid problems** ☐ poor ☐ good ☐ working on it	☐	☐	☐	16	**Cancer or Tumors** ☐ poor ☐ good ☐ working on it	☐	☐	☐
17	**Epilepsy or seizure disorders** ☐ poor ☐ good ☐ working on it	☐	☐	☐	18	**Fainting or dizzy spells** ☐ poor ☐ good ☐ working on it	☐	☐	☐
19	**Hepatitis or other liver disease** ☐ poor ☐ good ☐ working on it	☐	☐	☐	20	**Tuberculosis (TB)** ☐ poor ☐ good ☐ working on it	☐	☐	☐
21	**HIV + AIDS** ☐ poor ☐ good ☐ working on it	☐	☐	☐	22	**Kidney disease** ☐ poor ☐ good ☐ working on it	☐	☐	☐
23	**Hearing loss** ☐ poor ☐ good ☐ working on it	☐	☐	☐	24	**Vision loss** ☐ poor ☐ good ☐ working on it	☐	☐	☐
25	**Pregnant/Trying to Get Pregnant**	☐	☐	☐	26	**Breastfeeding**	☐	☐	☐
27	**Pacemaker** Reason: Date:	☐	☐	☐	28	**Chronic Pain:** ☐ poor ☐ good ☐ working on it	☐	☐	☐
29	**Seasonal Allergies** ☐ poor ☐ good ☐ working on it	☐	☐	☐	30	**Addictions, explain:** ☐ poor ☐ good ☐ working on it	☐	☐	☐
31	**Unusual Weight Loss** ☐ poor ☐ good ☐ working on it	☐	☐	☐	32	**Glaucoma, wide or narrow angle** ☐ poor ☐ good ☐ working on it	☐	☐	☐
33	**Special Diet/Healthy Diet** Reason: ☐ poor ☐ good ☐ working on it	☐	☐	☐	34	**Other Condition not listed** ☐ poor ☐ good ☐ working on it	☐	☐	☐

5. Are there any other problems or issues about your health that you know of?

☐**NO** ☐**YES** If yes, explain: _____

6. Have you ever taken medications that affect the bone or to prevent bone disease

e.g. bisphosphonates: Fosamax, Zometa, Actonel, Aredia

☐**NO** ☐**YES** If yes, dates started and ended_____

7. If you have answered yes to any of the questions above, and take Medications, Herbal Remedies or Supplements Please list them below with the reason it is taken. If there are more than 12 and you can provide a list, we can copy it for you. Please include oral contraceptives if taken.

Current Medications, Herbal Remedies, Vitamins, Supplements

	Prescription or Over the Counter Medication, Herbal Remedy, Vitamin or Supplements	**Amount Taken**	**How often is it taken?**	**Reason it is Taken**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

8. Have you ever used Alcohol or Tobacco Products or Vape? ☐**NO** ☐**YES** If yes, what kind, how much and how often:

	What kind?	**How much?**	**How often?**	**Did you quit? If yes, when?**
1				
2				
3				

9. Have you ever used any Illegal (recreational) drugs?

☐**NO** ☐**YES** If yes, please note the drug(s), amount, and when last taken:

_____

If yes to the two questions above, the patient was counseled recommending healthy changes and professional help.

10. Have you ever been Hospitalized or had a Major Operation or had Any Serious Illness? ☐**NO** ☐**YES**

11. Have you ever had any Head or Neck Trauma including any Motor Vehicle Accident or any Fall?

☐**NO** ☐**YES** If yes to either of the last two questions, please note them below. If there are more than 10 and you can provide a list, we can copy it for you.

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Hospitalizations, Major Operations, Serious Illness, Head or Neck Trauma, Fall, Motor Vehicle Accidents

	Date	Condition	Outcome	How this Will Affect Dental Care Delivery for you.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

12. Do you have any Hearing or Vision Loss, or Loss of Mobility?

☐**NO** ☐**YES** If yes, note what it is and how you address it.

_____

13. Do you have a Healthy Diet, or are you on a Special Diet?

☐**NO** ☐**YES Please explain:**

_____

Although Dental Healthcare Providers primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interaction with the dentistry you will receive. Thank you for answering the previous questions as accurately as possible.

As a Dental Patient of Dentistry by Design of Cary, I understand that providing incorrect information can be dangerous to my (or my child's) health.

It is my responsibility to inform this dental office of any changes in my (or my child's) medical and dental status at each dental visit to provide the best and safest dental treatment possible.
I understand that my (or my child's) health status will be verbally updated at each dental visit,
and I will sign a written update once per year as the standard of care requires.

Printed Name of the PERSON COMPLETING FORM: _____

If other than patient, indicate relationship to patient: _____

Date: _____ Signature:_____

Date: _____ Dental Provider'sSignature:_____