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901 Paverstone Dr., Ste. A Raleigh NC 27615

MEDICAL QUESTIONNAIRE - Patient name: ___________________________________

1. Are you having pain or discomfort at this time? ___Yes___No
2. Do you feel nervous about having dental treatment? ___Yes___No
3. Have you ever had a bad experience in a dental office? ___Yes___No
4. Have you been hospitalized in the past two years? ___Yes___No
5. Have you been under the care of a medical doctor during the past two years? ___Yes___No
6. What are some questions about dentistry and oral health that you have never had adequately answered for you?

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Physician's Name ______________________________Address ____

Physician's Phone ______________________________

7. Have you taken any medications or drugs during the past two years? ___Yes___No List ________________________
8. Are you now taking any medications, drugs, or pills? ___Yes___No List ________________________
9. Are you now taking any vitamins, supplements, or herbal therapy? ___Yes___No List ________________________
10. Are you aware of being allergic to any of the following?

__Aspirin __Erythromycin __Novacaine/Xylocaine __Scopolamine __Darvon __Local Anesthetic
__Other Antibiotics __Nembutal/Seconal __Penicillin __Tetracycline __Codeine __Nitrous Oxide

11. Are you aware of being allergic to any other medication of substance? ___Yes___No If yes, list ____________________
12. Check any of the following which you have had, or have at present:

__AIDS	__Cough	__Heart Pacemaker	__Rheumatic Fever	__Allergies/Hives	__Diabetes
__Heart Surgery	__Rheumatism	__Anemia	__Drug Addiction	__Hemophilia	__Scarlet Fever
__Angina Pectoris	__Hepatitis A	__Emphysema	__High Blood Pressure	__Artificial Joints	__Epilepsy
__Hepatitis B	__Arthritis	__Sickle Cell Disease	__Fainting / Dizzy Spells	__Seizures	__Sinus / Hay Fever
__Stroke	__Glaucoma	__Leukemia	__Blood Transfusion	__Bruise Easily	__Heart Attack
__Liver Disease	__ Heart Disease	__Chemotherapy	__Mitral Valve Prolapse	__Syphilis	__Thyroid
__Cold Sores	__Heart Failure	__Nervousness	__Cortisone Medicine	__Tuberculosis	__Heart Lesions
__Ulcers	__Heart Murmur	__Pain in Jaw Joints	__Cosmetic Surgery	__Venereal Diseases	__Psychiatric Trxt
__Yellow Jaundice		__X-ray/Cobalt Trxt			

13. Do you ever have shortness of breath or chest pains? ___Yes___No
14. Do you have any prosthetic joints, heart valves, etc.? ___Yes___No
15. Have you lost or gained more than ten pounds in the last year? ___Yes___No
16. Do you ever wake up from sleeping with shortness of breath? ___Yes___No
17. Have you taken Phen-Phen or Redux? ___Yes___No
18. Has your medical doctor ever said you have a cancer or tumor? ___Yes___No
19. Do you have any disease, condition, or problem not listed? ___Yes___No List ________________________
20. **Women only** Are you pregnant or think you may be? ___Yes___No
21. **Women only** Are you taking birth control pills? ___Yes___No
22. Which of the following have you been given? ___ CPAP ___ Orthodontic Retainer ___ Mouth splint/Night Guard
23. If so, how often do you wear these? ______________________ ___ Oral Device for Sleep Apnea/Snoring

Consent: *The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient)___________________________________ and further authorize consent that the doctor choose and employ such assistance as s/he deems fit. I also understand that responsibility for payment for dental services provides in this office for my dependents or myself is mine, due and payable at the time services are rendered. In the event of default, I(we) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees, as my be required, to effect collection of this note.*