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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
__Sleeping pills __Other Antibiotics __Nembutal/Seconal __Demoro __Penicillin __Tetracycline
__Codeine __Nitrous Oxide __Percodan __Valium

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 your ankles swell during the day? ___Yes___No
17. Do you ever wake up from sleeping with shortness of breath? ___Yes___No
18. Have you taken Phen-Phen or Redux? ___Yes___No
19. Has your medical doctor ever said you have a cancer or tumor? ___Yes___No
20. Do you have any disease, condition, or problem not listed? ___Yes___No List _________________________
21. **Women only** Are you pregnant or think you may be? ___Yes___No
22. **Women only** Are you taking birth control pills? ___Yes___No

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 may be required, to effect collection of this note.*