Charlotte Dental Esthetics

2809 COLTSGATE ROAD SUITE 210 CHARLOTTE, NC 28211
Ph: 704-375-4252 | Fax: 704-364-8353 Email: Info@CharlotteRootCanalCenter.com

FIRST NAME	LAST NAME	MIDDLE NAME
PHONE NUMBER	BIRTH	SOCIAL SECURITY (INSURANCE PURPOSES)
ADDRESS	CITY, STATE, ZIP CODE	OCCUPATION/EMPLOYER
GENERAL DENTIST NAME	DENTIST PHONE NUMBER/EMAIL	YOUR EMAIL

MEDICAL HISTORY

1. DO YOU HAVE UNHEALED ORAL INJURIES, GROWTHS, OR SPOTS IN YOUR MOUTH? 1. YES ☐ NO ☐
2. HAS THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? 2. YES ☐ NO ☐
3. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR A CURRENT PROBLEM? 3. YES ☐ NO ☐
4. HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS? 4. YES ☐ NO ☐
5. HAVE YOU RECEIVED DRUG ADDICTION OR ALCOHOL THERAPY IN THE PAST 5 YEARS 5. YES ☐ NO ☐
6. HAVE YOU EVER HAD ALLERGIC OR ADVERSE REACTIONS TO MEDICATIONS? WHICH ONES? 6. YES ☐ NO ☐
7. IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? 7. YES ☐ NO ☐
8. DO YOU WISH TO SPEAK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING? 8. YES ☐ NO ☐
9. HAVE YOU HAD ABNORMAL BLEEDING WITH PREVIOUS EXTRACTIONS OR SURGERIES? 9. YES ☐ NO ☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? 10. YES ☐ NO ☐
11. HAVE YOU EVER HAD SURGERY AND/OR RADIATION FOR A TUMOR, GROWTH, OR CONDITION? 11. YES ☐ NO ☐
12. HAVE YOU EVER TESTED POSITIVELY FOR HIV VIRUS OR AIDS? IF SO, STATE DATE AND DOCTOR. 12. YES ☐ NO ☐
13. ARE YOU REQUIRED TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT? Some conditions Require this. 13. YES ☐ NO ☐
14. ARE YOU PREGNANT, NURSING OR ON BIRTH CONTROL? 14. YES ☐ NO ☐

15. HAVE YOU OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS

IF NONE, CHECK HERE ☐

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMUR
- ☐ JOINT PROSTHESIS
- ☐ RHEUMATIC FEVER
- ☐ CONGENITAL HEART DISEASE
- ☐ HEART DIS, ATTACK, STROKE
- ☐ PROSTHETIC HEART VALVE
- ☐ BLOOD DISORDER
- ☐ VENEREAL DISEASE
- ☐ ASTHMA
- ☐ ALLERGY TO LATEX
- ☐ LOW BLOOD PRESSURE
- ☐ CHEST PAIN ANGINA
- ☐ ARTHRITIS JOINT DIS.
- ☐ CARDIAC PACEMAKER
- ☐ HEART SURGERY
- ☐ DELEY IN HEALING
- ☐ TUBERCULOSIS
- ☐ EMPHYSEMA
- ☐ CHEMOTHERAPY
- ☐ ON A DIET
- ☐ ALCOHOL ABUSE
- ☐ EYE DIS. GLAUCOMS
- ☐ MONONUCULEOSIS
- ☐ SINUS TROUBLE
- ☐ THYROID PROBLEMS
- ☐ DIABETES
- ☐ STOMACH ULCERS, COLITIS
- ☐ HEPATITUS, LIVER DIS.
- ☐ KIDNEY PROBLEMS
- ☐ PSYCHIATRIC TREATMENT
- ☐ FAINTING, SEIZURES
- ☐ EPILEPSY
- ☐ CANCER
- ☐ TMJ, JAW PAIN
- ☐ DIALISIS
- ☐ IRREG. HEARTBEAT
- ☐ CONTAGIOUS DISEASES
- ☐ BRONCHITIS, CHRONIC COUGH
- ☐ HAY FEVER
- ☐ IMMUNE SYSTEM PROBLEMS
- ☐ DIFFICULTY BREATHING
- ☐ CHRONIC FATIGUE
- ☐ HISTORY OF DRUG ABUSE
- ☐ WEAR CONTACT LENSES
- ☐ BRUISE EASILY
- ☐ GALLBLADDER TROUBLE

16 ARE YOU TAKING HERBAL MEDICATION (I.E. ST. JOHN'S WORT) **YES** ☐ **NO** ☐

17. HAVE YOU EVER TAKEN THE "FEN-PHEN" DIET? **YES** ☐ **NO** ☐

18. DO YOU HAVE ANY CONDITION OR DISEASES NOT LISTED ABOVE? IF YES LIST THEM BELOW

19. ARE YOU TAKING ANY MEDICATION OR DRUGS? PLEASE LIST BELOW.

ARE YOU ALLERGIC TO ANYTHING?

SIGNATURE DATE