CAROLINA MOMF IMAGING

Combining Advanced Diagnostics With Knowledge and Experience

Health History

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, highlite a number or letter. This Health History Questionnaire will become a part of the patient's dental record and will be considered confidential information.

PATIENT NAME:	TODAY'S DATE:		
BIRTH DATE:			
Primary Care Physician:			
Physician Office Telephone:			
Physician Address:			
1. Are you in good health?	☐Yes	☐No	☐Unsure
2. Has there been any change in your health in the last year?	☐Yes	☐No	☐Unsure
If yes, explain:			
3. Have you ever been hospitalized, had a major operation or serious illness?	☐Yes	☐No	☐Unsure
If yes, explain:			
4. Date of your last visit to the doctor:	Reason for last visit:		
5. Are you currently receiving treatment or regular medical care by your doctor?	☐Yes	☐No	☐Unsure
If yes, for what condition(s)?			
6. Are you taking any of the following medications:			
a. Antibiotics or sulfa drugs	☐Yes	☐No	☐Unsure
b. Anticoagulant (blood thinners)	☐Yes	☐No	☐Unsure
c. Medication for high blood pressure	☐Yes	☐No	☐Unsure
d. Cortisone (steroids)	☐Yes	☐No	☐Unsure
e. Tranquilizers	☐Yes	☐No	☐Unsure
f. Antihistamines	☐Yes	☐No	☐Unsure
g. Aspirin	☐Yes	☐No	☐Unsure
h. Insulin, tolbutamide (Orinase) or other drugs for diabetes	☐Yes	☐No	☐Unsure
i. Digitalis or drugs for heart trouble	☐Yes	☐No	☐Unsure
j. Nitroglycerin	☐Yes	☐No	☐Unsure
k. Birth control pills or other hormones	☐Yes	☐No	☐Unsure
I. Pain medications such as Advil, Nuprin, Motrin or Naprosyn	☐Yes	☐No	☐Unsure
m. Synthroid or other thyroid medication	☐Yes	☐No	☐Unsure
n. AZT or other drugs for HIV	☐Yes	☐ No	☐Unsure
o. Others, please list:			
7. Have you ever taken fen-phen (fenfluramine/phentermine combination)?	☐Yes	☐No	☐Unsure
If so, have you had a cardiac (heart) exam by your physician? If yes, specify what substance/medications, and what reactions:			
HAVE YOU EVER BEEN TREATED BY A DOCTOR FOR:(Circle your response and underline any conditions that apply):			
9. Damaged heart valves, artificial heart valves, heart	☐Yes	☐No	☐Unsure
murmur, rheumatic fever, rheumatic heart disease			
10. Congenital heart problems	☐Yes	☐No	☐Unsure
11. Heart trouble, heart attack, high blood pressure, stroke?	☐Yes	☐No	☐Unsure
a. Do you have pain in your chest upon exertion?	☐Yes	☐No	☐Unsure
b. Are you ever short of breath after mild exercise?	☐Yes	☐No	☐Unsure
c. Do your ankles swell?	☐Yes	☐No	☐Unsure
14. Breathing problems, emphysema, tuberculosis or	☐Yes	☐No	☐Unsure
other lung problems?			
15. Asthma, hay fever or hives?	☐Yes	☐No	☐Unsure
16. Stomach or intestinal ulcers?	☐Yes	☐No	☐Unsure
17. Cancer, x-ray treatments, or chemotherapy?	☐Yes	☐No	☐Unsure

18. Thyroid trouble?	☐Yes	☐No	☐Unsure
19. Diabetes or blood sugar problems?	☐Yes	☐No	☐Unsure
20. Hepatitis, jaundice, or liver disease?	☐Yes	☐No	☐Unsure
21. Kidney infections, frequent urination, or renal (kidney) dialysis?	☐Yes	☐No	☐Unsure
22. Stroke, seizures, fainting spells, numbness or other neurological problems?	☐Yes	☐No	☐Unsure
24. AIDS, AIDS-related condition or HIV positive?	☐Yes	☐No	☐Unsure
25. Tumors or growths?	☐Yes	☐No	☐Unsure
26. Arthritis or rheumatism?	☐Yes	☐No	☐Unsure
27. Phobias, severe anxieties, depression, psychoses, unusual fears, or other mental problems?	☐Yes	☐No	☐Unsure
28. Psoriasis, seborrhea, or other skin diseases?	☐Yes	☐No	☐Unsure
29. **For women**, are you pregnant or do you think you may be pregnant?	☐Yes	☐No	☐Unsure
30. **For women**, are you nursing?	☐Yes	☐No	☐Unsure
OTHER MEDICAL CONCERNS:			
31. Do you have complaints regarding your eyes, ears or nose?	☐Yes	☐No	☐Unsure
If yes, explain:			
32. Do you wear contact lenses?	☐Yes	☐No	☐Unsure
33. Have you received blood or blood by-products?	☐Yes	☐No	☐Unsure
If so, please list: type: amount: date:			

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM:

Signature of Patient:_____

(If other than patient, indicate relationship):_____

Date:_____