Goldsboro Dental Arts

Shaun White DMD

Patient Medical History

Please take a moment to answer the following important health related questions so that we may provide the best possible patient care for you.

Patient Name: _____

Primary Physician's Name: _____ Phone #: _____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N ADHD
Y N Allergies
Y N Anemia
Y N Angina Pectoris
Y N Anxiety/Depression
Y N Autism
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Heart Valve
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Dementia/Alzheimer's
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Date: _____
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N Herpes
Y N High Blood Pressure
Y N HIV/AIDs
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker/Heart Surgery
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Reflux
Y N Rheumatic Fever
Y N Seizures/Epilepsy
Y N Shingles
Y N Sickle Cell/Anemia Traits
Y N Sinus Problems
Y N Stroke/Date: _____
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers/Colitis
Y N Venereal Disease/STDs

Do you have any of the following allergies?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Metals/Jewelry
Y N Penicillin
Y N Sulfa
Y N Tetracycline
OTHER? _____

For FEMALES ONLY:

Y N Are you taking birth control pills?
Y N Are you nursing?
Y N Are you pregnant?
# of weeks: _____

Have you been told by your medial doctor if you require antibiotic prior to dental treatment? Y N
Do you smoke or use tobacco? Y N
Have you ever used the drug "Fen-Phen"? Y N
Have you taken Fosamax, Actonel, Boniva, or any other bisphosphonate? Y N
Have you ever been hospitalized? Y N
If yes, please explain: _____
Please list any other conditions: _____
Please list any medications you are currently taking: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____