

MEDICAL HISTORY

**CAROLINA DENTAL CENTER
R. Jason Meares, DDS, PA**

Date _____

Name _____

GENERAL HEALTH: Excellent ___ Good ___ Fair ___ Poor ___

PHYSICIAN'S NAME _____ ADDRESS _____
PHYSICIAN'S PHONE _____ DATE OF LAST EXAM _____

DO YOU NOW HAVE ... OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
___	___	Any heart problems	___	___	Asthma	___	___	Thyroid problems
___	___	High blood pressure	___	___	Diabetes	___	___	Epilepsy
___	___	Heart or valve surgery	___	___	Hepatitis	___	___	Tuberculosis
___	___	Heart murmur	___	___	Herpes	___	___	Kidney problems
___	___	Circulatory problems	___	___	Malignancy	___	___	Venereal disease
___	___	Excessive bleedings	___	___	Persistent cough	___	___	Joint replacement
___	___	Aids/HIV	___	___	Psychiatric care	___	___	___ Steroid use
___	___	Nervous problems	___	___	Rheumatic fever	___	___	Arthritis
___	___	Allergies	___	___	Scarlet fever	___	___	Mouth ulcers
___	___	Allergic to anesthesia	___	___	Sinus problems	___	___	___ Pregnant?
___	___	Allergic to drugs	___	___	Stroke			
		List: _____						

Is there any additional information your dentist should know about your health?

ARE YOU NOW TAKING ANY MEDICATIONS? Yes ___ No ___

List medications:
