1321 OBERLIN ROAD
RALEIGH, NC 27608
PHONE: 919-821-0008

Jeffrey C. Calamos, DDS
Patrick F. Marsh, DDS
Samuel R. Emrich, DDS

660 HWY 42 WEST
CLAYTON, NC 27520
PHONE: 919-553-5652

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of the entire body. Health problems that you may have or medications that you may be taking, could have an important interrelationship with the dental treatment you will receive. Thank you for answering the following questions.

Physician _____ Date of Last Exam _____

1. Are you under medical treatment now? _____ yes _____ no
2. Have you ever been hospitalized for any surgery or serious illness:? _____ yes _____ no
   What _____
3. Do you use tobacco products? _____ yes _____ no
4. Do you use alcohol or other drugs? _____ yes _____ no
5. **Women Only**
   Are you pregnant or think you may be pregnant ? _____ yes _____ no
   Are you nursing? _____ yes _____ no
6. Have you had any allergies or allergic reactions? _____ yes _____ no
   Explain _____
7. Are you taking any medications including non-prescription and herbal? Please list all:

Do you have or have had, any of the following?

Abnormal Weight loss/gain	❑ yes	❑ no	Cong Heart disorder	❑ yes	❑ no	Hemophilia	❑ yes	❑ no	Pacemaker	❑ yes	❑ no
AIDS / HIV positive	❑ yes	❑ no	Diabetes	❑ yes	❑ no	Hepatitis A	❑ yes	❑ no	Pain in jaw joint	❑ yes	❑ no
Alzheimer's Disease	❑ yes	❑ no	Drug addiction	❑ yes	❑ no	Hepatitis B, C	❑ yes	❑ no	Psychiatric Care	❑ yes	❑ no
Anemia	❑ yes	❑ no	Easily winded	❑ yes	❑ no	High Blood Pressure	❑ yes	❑ no	Renal Disease	❑ yes	❑ no
Angina	❑ yes	❑ no	Emphysema	❑ yes	❑ no	Hives/Rash	❑ yes	❑ no	Rheumatic Fever	❑ yes	❑ no
Arthritis	❑ yes	❑ no	Endocarditis	❑ yes	❑ no	Intestinal Disease	❑ yes	❑ no	Scarlet Fever	❑ yes	❑ no
Artificial Valve	❑ yes	❑ no	Epilepsy or seizure	❑ yes	❑ no	Irreg heartbeat	❑ yes	❑ no	Shingles	❑ yes	❑ no
Asthma	❑ yes	❑ no	Excessive bleeding	❑ yes	❑ no	Joint replacement	❑ yes	❑ no	Sickle Cell	❑ yes	❑ no
Blood Disorder	❑ yes	❑ no	Excessive thirst	❑ yes	❑ no	(pins/plates)			Sinus Trouble	❑ yes	❑ no
Breathing Problem	❑ yes	❑ no	Fainting/Dizziness	❑ yes	❑ no	-body part _____			Stroke	❑ yes	❑ no
Bruise Easily	❑ yes	❑ no	Frequent cough	❑ yes	❑ no	-year _____			Swelling limbs	❑ yes	❑ no
Cancer	❑ yes	❑ no	Frequent headaches	❑ yes	❑ no	Kidney problems	❑ yes	❑ no	Thyroid Disease	❑ yes	❑ no
-type _____			Glaucoma	❑ yes	❑ no	Leukemia	❑ yes	❑ no	Tuberculosis	❑ yes	❑ no
-year _____			Hay Fever	❑ yes	❑ no	Liver dis./Jaundice	❑ yes	❑ no	Tumors/grow	❑ yes	❑ no
Chest Pains	❑ yes	❑ no	Heart attack/failure	❑ yes	❑ no	Low blood pressure	❑ yes	❑ no	Ulcers	❑ yes	❑ no
Chemo/radiation	❑ yes	❑ no	Heart murmur	❑ yes	❑ no	Lung Disease	❑ yes	❑ no	Venereal Disease	❑ yes	❑ no
Cold Sore / Fever Blister	❑ yes	❑ no	Heart Trouble	❑ yes	❑ no	Mitral Valve prolapse	❑ yes	❑ no			

Any other illnesses or conditions not listed? ❑ yes ❑ no Explain _____

Have you ever experienced any of the following problems with your jaw?

Clicking? ❑ yes ❑ no Pain in the cheek or joint area? ❑ yes ❑ no Difficulty opening / closing? ❑ yes ❑ no Difficulty chewing? ❑ yes ❑ no

Do you clench or grind your teeth? ❑ yes ❑ no Day _____ Night _____ Both _____

Do you bite your lips or cheeks frequently? ❑ yes ❑ no

Medical History Changes / Updates

Date	Initial	List
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that I have read and understand the above information. I understand it is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Patient, Parent or Guardian Date