

MEDICAL HISTORY

NAME: _____ **Date of Birth:** _____

Date: _____
 Update: _____
 Update: _____
 Update: _____

<p>Have you ever had:</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Diabetes</td><td>Yes</td><td>No</td></tr> <tr><td>Epilepsy</td><td>Yes</td><td>No</td></tr> <tr><td>Hepatitis</td><td>Yes</td><td>No</td></tr> <tr><td>HIV/AIDS</td><td>Yes</td><td>No</td></tr> <tr><td>Hemophilia</td><td>Yes</td><td>No</td></tr> <tr><td>Cancer</td><td>Yes</td><td>No</td></tr> <tr><td>Ulcer</td><td>Yes</td><td>No</td></tr> <tr><td>High blood pressure</td><td>Yes</td><td>No</td></tr> <tr><td>Radiation treatment</td><td>Yes</td><td>No</td></tr> <tr><td>Tuberculosis</td><td>Yes</td><td>No</td></tr> </table>	Diabetes	Yes	No	Epilepsy	Yes	No	Hepatitis	Yes	No	HIV/AIDS	Yes	No	Hemophilia	Yes	No	Cancer	Yes	No	Ulcer	Yes	No	High blood pressure	Yes	No	Radiation treatment	Yes	No	Tuberculosis	Yes	No	<table style="width: 100%; border-collapse: collapse;"> <tr><td>Sickle cell anemia</td><td>Yes</td><td>No</td></tr> <tr><td>Prosthetic heart valve</td><td>Yes</td><td>No</td></tr> <tr><td>History of endocarditis</td><td>Yes</td><td>No</td></tr> <tr><td>Organic heart murmur</td><td>Yes</td><td>No</td></tr> <tr><td>Mitral valve prolapse</td><td>Yes</td><td>No</td></tr> <tr><td>Pacemaker</td><td>Yes</td><td>No</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </table>	Sickle cell anemia	Yes	No	Prosthetic heart valve	Yes	No	History of endocarditis	Yes	No	Organic heart murmur	Yes	No	Mitral valve prolapse	Yes	No	Pacemaker	Yes	No	_____	_____	_____	_____	_____	_____
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<p>Are you allergic or had a reaction to:</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Penicillin</td><td>Yes</td><td>No</td></tr> <tr><td>Aspirin</td><td>Yes</td><td>No</td></tr> <tr><td>Codeine</td><td>Yes</td><td>No</td></tr> <tr><td>Erythromycin</td><td>Yes</td><td>No</td></tr> <tr><td>Dental numbing/anesthetic</td><td>Yes</td><td>No</td></tr> </table>	Penicillin	Yes	No	Aspirin	Yes	No	Codeine	Yes	No	Erythromycin	Yes	No	Dental numbing/anesthetic	Yes	No	<p>Other drugs: _____ Yes No</p> <p>What? _____</p> <p>_____</p>																																							
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Has a medical doctor advised taking antibiotics prior to dental treatment due to concerns for your heart or replacement joint?	Yes	No
Are you taking aspirin every day?	Yes	No
Are you taking any drugs or medications? What? _____ for what? _____ What? _____ for what? _____ What? _____ for what? _____ What? _____ for what? _____		
Do you have any disease, condition or problem not listed above that I should know about? If so, explain _____	Yes	No
Women: Are you pregnant or nursing? Are you taking birth control pills?	Yes	No
Medical Doctor's Name _____ City _____ Phone # _____		

DENTAL HISTORY
Why are you seeking dental care at this time? _____
Are you having dental pain? _____
Have you had a dental examination in the last 2 years? _____ Were x-rays taken during that examination? _____
Have you had any serious trouble with any previous dental treatment? _____
Do you use tobacco products? Yes No What? _____
_____ Date _____
Signature of person completing medical history

Dr. Henry D. Duncan, DDS, PA
814 Sloop Avenue
Kannapolis, NC 28083

Authorization To Consent to Dental Care for Minor

I, _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____, 20 _____. I authorize Dr. Henry D. Duncan, to do any acts which may be necessary or proper to provide for the dental care of the minor child, including, but not limited to, administration of anesthesia, X-ray examination, performance of dental surgery and other dental procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and to assign the dental treatment decisions covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

Signature

Date

Staff