Dr Frajovon R. Talley, DDS, PLLC
3716 West WT Harris Blvd. Suite G
Charlotte, NC 28269
(704) 599-8230

Dental and Medical History Form

Date: _____

Patient Name _____ Patient Number _____

Reason for Appointment _____

Previous Dentist's Name/Address/Phone	Physician's Name/Address/Phone

Answers to the questions below will help your dentist decide how to best treat your dental problems. If you do not know the answer to a question, please leave it blank. If you need help in completing the form, please tell the receptionist.

Dental History

1. When was your last dental checkup? _____
2. When were your teeth cleaned last? _____
3. When were your last dental x-rays taken? _____
4. Have you had missing teeth replaced by bridgework or dentures? _____
5. Are you happy with the appearance of your teeth? . . . . . ☐ Yes ☐ No
6. Do you have any apprehension (fear) related to dental treatment? . . . . . ☐ Yes ☐ No
7. Have you ever bled excessively after a tooth extraction? . . . . . ☐ Yes ☐ No
8. What did you dislike most about your previous dental experience? _____
   _____
9. What did you like most about your previous dentist? _____
   _____

Medical History

10. Have there been any changes in your health within the past year? . . . . . ☐ Yes ☐ No
    If yes, explain _____
11. Have you had treatment by a physician within the past year?. . . . . ☐ Yes ☐ No
    If yes, explain _____
12. Have you ever had major surgery or been hospitalized for any reason?. . . . . ☐ Yes ☐ No
    If yes, explain _____
13. Are you currently taking any medication (birth control pills included)? . . . . . ☐ Yes ☐ No
    If yes, list _____
    _____
14. Are there any medications that make you sick or ill? . . . . . ☐ Yes ☐ No
    If yes, explain _____
15. Are you allergic to anything? . . . . . ☐ Yes ☐ No
    If yes, explain _____
16. (Women) a. Are you pregnant? If yes, what is the due date? _____. . . . . ☐ Yes ☐ No
    b. Do you have any problems associated with your period? . . . . . ☐ Yes ☐ No

	Yes	No
17. Hepatitis	☐	☐
18. Jaundice; other liver disorder	☐	☐
19. Blood transfusion(s)	☐	☐
20. Refusal for blood donation	☐	☐
21. AIDS / HIV- positive test as carrier of AIDS virus	☐	☐
22. Hemophilia; other bleeding disorder	☐	☐
23. Prolonged bleeding from a cut, injury or surgery	☐	☐
24. Venereal disease (VD)	☐	☐
25. Oral ulcers or sores	☐	☐
26. Tuberculosis	☐	☐
27. Positive TB Test	☐	☐
28. Shortness of breath with normal activity	☐	☐
29. Asthma	☐	☐
30. Anemia; low or thin blood	☐	☐
31. Kidney or bladder disorder	☐	☐
32. Sugar diabetes	☐	☐
33. Thyroid disorder	☐	☐
34. Fainting spells or blackouts	☐	☐
35. Seizures, convulsions or epilepsy	☐	☐
36. Stomach or intestinal ulcers	☐	☐
37. Rheumatic fever	☐	☐

	Yes	No
38. Congenital Heart defect	☐	☐
39. Heart murmur	☐	☐
40. Heart attack	☐	☐
41. Angina; severe chest pain	☐	☐
42. Heart surgery	☐	☐
43. Cardiac pacemaker	☐	☐
44. Other heart disease	☐	☐
45. High blood pressure	☐	☐
46. Low blood pressure	☐	☐
47. Stroke	☐	☐
48. Tumor or Cancer	☐	☐
49. Radiation, or X-ray, treatment	☐	☐
50. Artificial limb, joint, heart valve or other prosthesis	☐	☐
51. Organ transplant	☐	☐
52. Bone, joint or muscle problems	☐	☐
53. Visual problems	☐	☐
54. Hearing problems	☐	☐
55. Emotional problems	☐	☐
56. Alcohol abuse	☐	☐
57. Drug abuse	☐	☐
58. Use of tobacco products	☐	☐
59. Other _____		

To the best of my knowledge, the foregoing questions have been accurately answered. During treatment, I will report any changes in my health; illness; hospitalization; or additional and/or change in medication to these above.

PATIENT SIGNATURE _____

FOR DENTIST'S USE ONLY

Question # Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

Vital Statistics: BP _____ Pulse _____ Temp _____ Weight _____

DENTIST SIGNATURE _____