Charlotte Family Dentistry

Patrick Gadola, D.D.S., P.C.

Adult Patient History and Information

(Confidential Information: Important for our files and your health)

Full Name _____ Birth Date _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Bus. Phone _____

Employed By _____ Social Security # _____

Dental Ins., Address & Phone _____

Spouse's Name _____ Birth Date _____

Home Phone _____ Cell Phone _____ Bus. Phone _____

Employed By _____ Social Security # _____

Dental Ins., Address & Phone _____

Family Doctor _____ Referred By _____

Patient Pharmacy _____

1. Are you allergic to Penicillin?..... Yes No
2. Are you sensitive/allergic to any other drugs or medicines?..... Yes No
   If yes, please list: _____
3. Are your ankles often swollen?..... Yes No
4. Do you get short of breath easily?..... Yes No
5. Do you faint easily?..... Yes No
6. Do you suffer from stomach trouble?..... Yes No
7. Have you gained or lost much weight recently?..... Yes No
8. Have you ever been exposed to HIV or AIDS virus?..... Yes No
9. Have you been under a doctor's care within the past year?..... Yes No
   If yes, please specify: _____
10. Are you taking medication at the present time?..... Yes No
    List: _____
11. Are you currently taking Bisphosphonates (bone enhancing drugs) such as, but not limited to, Actonel, Boniva, Fosamax, Reclast?..... Yes No
12. Are you pregnant?..... Yes No
13. Do you smoke or use tobacco? If yes, please specify: _____
14. If you have/had any of the illnesses listed below, please check the appropriate box:

❑ Asthma	❑ Tuberculosis	❑ High Blood Pressure	❑ Hepatitis
❑ Convulsions	❑ Latex Allergy	❑ Allergies	❑ Venereal Disease
❑ Heart Trouble	❑ Kidney Trouble	❑ Diabetes	❑ Hearing Loss
❑ Lupus	❑ Anemia	❑ Arthritis	❑ Cancer
❑ Epilepsy	❑ Cerebral Palsy	❑ Liver Problems	❑ Osteoporosis
❑ Prosthetic Joint Surgery		❑ COPD	❑ Fibromyalgia
❑ Degenerative Eye Conditions			

Is there anything about your general health we should know? If yes, please explain:

_____

_____

_____

_____

COMMENTS

PATIENT/GUARDIAN'S SIGNATURE _____ DATE_____