MEDICAL HISTORY
(PLEASE FILL OUT BOTH SIDES OF FORM)

Patient Name (please print): ______________________________ Today's Date: ________________

If you are completing this form for the patient, what is your name and relationship: ________________________

Please answer the following questions to the best of your ability. True and accurate answers are important for your safety.
ALL INFORMATION YOU PROVIDE WILL BE KEPT CONFIDENTIAL.

1. Are you in good health? ________________________________
2. Has there been any change in your health in the past year? ________________________
3. Date of last physical exam: __________ Physician: ________________ Phone #: ______________
4. For what conditions are you currently being treated by your physician or other specialist: ______________
   ____
5. List any serious illnesses, operations or hospitalizations within the past 5 years with dates: ______________
   ____
6. List orthopedic joint replacements (knee, hip, elbow, shoulder, etc) with dates: ________________
   ____
7. Do you require antibiotic premedication for dental treatment? ________________________
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis, chemotherapy for multiple myeloma, other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? ________________________
9. Have you ever been advised **not** to take a medication? ________________________
10. Do you have a history of opioid or substance abuse? ________________________
11. Please list any prescription or over the counter medicines (including vitamins and herbal supplements) you are taking:

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WOMEN ONLY: Are you Pregnant? ________ Number of weeks: __________

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

12. **Do you have or have you had any of the following diseases or problems?**

Y N Rheumatic Fever or Rheumatic Heart Disease
Y N Congenital Heart Disease
Y N Cardiovascular Disease (Heart Attack, Chest Pain, Heart Murmur, Coronary Artery Disease, Angina, Stroke, Palpitations, Mitral Valve Prolapse, Heart Surgery, Pacemaker, etc)
Y N High / Low Blood Pressure
Y N Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, etc)
Y N Seizures, Convulsions, Epilepsy, Fainting or Dizziness
Y N Bleeding Disorders, Anemia, Bleeding Tendency, Blood Transfusion, Bruise easily

(OVER)

Y N Liver Disease (Jaundice, Hepatitis, Cirrhosis, etc)
Y N Kidney Disease
Y N Diabetes
Y N Thyroid Disease (Goiter, Hyper, Hypo, etc)
Y N Arthritis
Y N Stomach Ulcers, Colitis, Crohn's, IBS
Y N Glaucoma or other eye problems
Y N Osteoporosis
Y N Non-dental implants anywhere in your body (Heart Valve, Pacemaker): ____________________
Y N Radiation (X-ray) treatment for Cancer
Y N Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth
Y N Sinus or Nasal problems
Y N Any disease, or transplant operation that has depressed your Immune system
Y N Mental health disorders: ____
Y N Severe headaches/migraines
Y N AIDS or HIV infection
Y N Recurrent infections of any kind: ____

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Are you allergic to or have you had any unusual reactions to:

Y N Penicillin, Amoxicillin, Cephalosporins, Erythromycin, Azithromycin, Clindamycin

Y N Other antibiotics: ______________________________

Y N Local anesthetic (Novocaine-like drugs) ____________________

Y N Barbiturates, sedatives ______________________

Y N Aspirin, Ibuprofen, NSAIDS, or other pain medications ____________________

Y N Codeine or other narcotics

Y N Latex or rubber products

Please list any other allergies, sensitivities or reactions: ____

____

Do you have any disease, condition, or problem not listed above? ___________________________________

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Do you wish to talk to the doctor about anything privately? YES NO

Note: You are encouraged to discuss any and all health issues with the endodontist prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for safely treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

______________________________	____________	________________
Signature of Patient/Legal Guardian	**Date**	**Doctor's Initials**

THANK YOU. Please return this form to the receptionist before completing others: (3/21)

FOR COMPLETION BY ENDODONTIST

Comments:

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