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Diplomate of the American Board of Endodontics
Practice Limited To Endodontics

MEDICAL HISTORY

Date____________________
Name____________________
Address____________________
City__________ State_____ Zip_______
Home Phone____________________
Cell Phone____________________

Birthdate____________________ Sex____M____F

Adult Patient or Parent:
Employed by____________________
Work Address____________________
City__________ State_____ Zip_______
Work Phone____________________
Parent or Guardian if under 18____________________
In case of emergency, Call____________________
Ph#/Relationship____________________

Referred by____________________
Reason for Dental visit____________________
Dental Insurance____________________

Physician Name____________________
Physician Address____________________
Physician Phone____________________

Only to be completed if asked, please mark in red

Updates: Date__________ Signature__________ | Date__________ Signature__________ | Date__________ Signature__________

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information.

HAVE YOU EVER HAD OR DO YOU HAVE:

Please Check Yes or No. *****If Yes, Circle All That Apply.*****	**YES**	**NO**
1. Hay Fever, Sinusitis or other allergies including Latex/Rubber Allergy?		
2. Allergy to penicillin, aspirin, local or general anesthetic **or other drugs?**		
3. Blood pressure or heart problems?		
4. Rheumatic fever, heart murmur, mitral valve prolapse, or bacterial endocarditis?		
5. A pacemaker or open heart surgery?		
6. Diabetes, liver, kidney, thyroid problems?		
7. Lung problems, Emphysema, Tuberculosis, Asthma, or Sleep Apnea?		
8. Ulcers or stomach problems, GERD (gastric reflux)?		
9. Hepatitis or Jaundice?		
10. Epilepsy or Nervous Disorders?		
11. Bleeding or clotting problems following a cut or tooth extraction?		
12. Arthritis, Artificial Hip(s), Knee(s), Shoulder(s) or Joint(s) ?		
13. Venereal Disease, Herpes?		
14. Acquired Immune Deficiency Syndrome (AIDS) or HIV infection?		
15. Do you smoke tobacco or use smokeless tobacco?		
16. Do you consume alcoholic beverages?		
17. Any other illness/disease/condition not listed?		
18. When was your last physical exam? **Date**		
19. Are you or have you ever taken Osteoporosis/bone loss drugs (Fosamax, Actonel, Zometa, Aredia, Boniva), Bisphosphates, Prolia etc.?		
20. Are you presently taking any medicine? Specify		
21. Do you take aspirin?		
22. Are you presently taking any herbal medicine? Specify		
23. Have you used or taken Fen-Phen/Redux?		
24. Have you had radiation therapy or chemotherapy?		
25. Women – do you take birth control pills/patch/injection?		
26. Women – are you pregnant?		
27. Do you have pain in your jaw or near your ears?		
28. Do you have any growths or inflamed areas in your mouth?		
29. When was your last dental exam? __________ Dental X-ray?__________		

Patient Signature __________ **Date** __________

Doctor Signature __________ **Date** __________