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Diplomate of the American Board of Endodontics

Practice Limited To Endodontics

MEDICAL HISTORY

Date _____	Adult Patient or Parent: _____
Name _____	Employed by _____
Address _____	Work Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Work Phone _____
Cell Phone _____	Parent or Guardian if under 18 _____
Birthdate _____ Sex M _____ F _____	In case of emergency, Call _____
	Ph#/Relationship _____

Referred by _____	Physician Name _____
Reason for Dental visit _____	Physician Address _____
Dental Insurance _____	Physician Phone _____

Only to be completed if asked, please mark in red

Updates: Date _____	Date _____	Date _____
Signature _____	Signature _____	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:

		YES	NO
1. Hay Fever, Sinusitis or other allergies including Latex/Rubber Allergy? _____	***If Yes, Circle All That Apply.***	/	/
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) 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 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 _____
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