

# Endodontic Specialists, P.C.

## Patient Medical History (confidential)

Today's Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone No. \_\_\_\_\_

List any surgeries you have had in last 5 years \_\_\_\_\_

List all medications you are currently taking \_\_\_\_\_

List any serious head, face or neck injury \_\_\_\_\_

Do you need to premedicate prior to dental work?  Yes  No

If yes, reason \_\_\_\_\_, medication \_\_\_\_\_

Do you, or have you taken, Phen-Fen or Redux?  Yes  No Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No Are you on a special diet?  Yes  No

### Female Patients Only:

Are you pregnant or trying to get pregnant?  Yes  No Are you nursing?  Yes  No

Are you taking oral contraceptives?  Yes  No

Are you allergic to any of the following? \_\_\_\_\_  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs  Barbiturates  
 Sedatives  Iodine  Other \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pacemaker*	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

List any serious illness or injury not listed above \_\_\_\_\_

\*Condition may require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

Doctor Comments: \_\_\_\_\_