Endodontic Associates

Medical History – Please answer each question.

Patient Name (please print):_____

Are you taking medication for any of the following:

1. Heart Rate:	O Yes O No	13. Pain Medications:	O Yes O No
2. Blood Pressure:	O Yes O No	14. Antibiotics:	O Yes O No
3. Blood Thinner:	O Yes O No	15. Arthritis:	O Yes O No
4. Cholesterol:	O Yes O No	16. Asthma/Breathing:	O Yes O No
5. Diabetes:	O Yes O No	17. Thyroid:	O Yes O No
6. Migraines:	O Yes O No	18. Seizures:	O Yes O No
7. Chemotherapy:	O Yes O No	19. Birth Control:	O Yes O No
8. Anti-depressant:	O Yes O No	20. Hormones:	O Yes O No
9. Anti-anxiety	O Yes O No	21. Osteoporosis:	O Yes O No
11. Sleep Aids	O Yes O No	Other:_____	
12. Herbal Medications	O Yes O No	_____	

Do you or have you had any of the following:

1. Diabetes:	O Yes O No	10. Cancer:	O Yes O No
2. Hepatitis A,B,C,D:	O Yes O No	12. Stroke:	O Yes O No
3. Thrush:	O Yes O No	13. Artificial Joint:	O Yes O No
4. Herpes:	O Yes O No	14. Tuberculosis:	O Yes O No
5. Thyroid Problems:	O Yes O No	15. AIDS/HIV:	O Yes O No
6. Pacemaker:	O Yes O No	16. Chest Pain:	O Yes O No
7. Heart murmur:	O Yes O No	17. Mitral Valve Prolapse:	O Yes O No
8. Heart attack:	O Yes O No	18. High Blood Pressure:	O Yes O No
9. Ulcer/Stomach:	O Yes O No		

Are you allergic to any of the following:

1. Penicillin:	O Yes O No	5. Codeine:	O Yes O No
2. Aspirin:	O Yes O No	6. Dental Anesthesia:	O Yes O No
3. Demerol:	O Yes O No	7. Latex:	O Yes O No
4. Sulfa Drugs:	O Yes O No	8. Other: _____	

Do you **pre-medicate** with antibiotics prior to dental treatment
for an artificial joint or artificial heart valve? O Yes O No

Are there any other conditions you feel are important? O Yes O No

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_____

Signature of Patient or Guardian _____ Date _____