ENDODONTIC ASSOCIATES
EST 1964

Medical History – Please answer each question.

Patient Name (please print):_____

What medications are you currently taking:

_____

_____

Have you been prescribed any medications for **this tooth** (antibiotics/pain medication/steroids)? **Yes** **No**
If yes, please list: _____

Do you have or have you had any of the following:

Diabetes: **Yes** **No** If yes, what type? Type I Type II
Liver Disease: **Yes** **No** If yes, Hepatitis? A B C D Other: _____
Kidney Disorders: **Yes** **No**
Stomach/GI Issues (Ulcers, Reflux/GERD): **Yes** **No**
Heart Disease (angina/chest pain, heart attack, previous bypass surgery): **Yes** **No**
Do you have a pacemaker? **Yes** **No**
Asthma, COPD, other breathing issues: _____
Tuberculosis: **Yes** **No** If yes, when did you test positive? _____
Stroke: **Yes** **No** If yes, when was it? _____
Cancer: **Yes** **No** If yes, what type? _____ Was it treated with radiation? **Yes** **No**
Osteoporosis: **Yes** **No** Have you taken bisphosphonates (ie, Fosomax, Boniva, Reclast)? **Yes** **No**
Do you have any artificial joints? **Yes** **No** Where and when was the surgery?_____
Bleeding or clotting disorders? **Yes** **No**
High Blood Pressure? **Yes** **No**
Thyroid Problems? **Yes** **No**
Herpes (oral): **Yes** **No**
AIDS/HIV: **Yes** **No**

Women: Are you pregnant? **Yes** **No** If so, how far along? _____ weeks

Are you allergic to:

Penicillin: **Yes** **No** Latex: **Yes** **No** Other: _____

Do you normally **pre-medicate** with antibiotics prior to dental treatment for an artificial joint or artificial heart valve? **Yes** **No** If yes, did you take it prior to your appointment today? **Yes** **No**

Are there any other conditions you feel are important?

_____

_____

Patient Signature:_____ **Date** _____

Parent/Legal Guardian (If patient is under 18):

_____