Time 3:21 PM — MODERN ENDODONTICS — Date 2/7/2019

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you been hospitalized or had a major operation in the last 2 years?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Hepatitis A	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No	Herpes	Yes No
Rheumatic Fever	Yes No	Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No
Rheumatism	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Shingles	Yes No	Artificial Joint	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Kidney Problems	Yes No
Spina Bifida	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Frequent Headaches	Yes No
Liver Disease	Yes No	Stroke	Yes No	Low Blood Pressure	Yes No	Cancer	Yes No
Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No
Mitral Valve Prolapse	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Convulsions	Yes No
Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No				

Have you ever had any serious illness not listed above? Yes No If yes

Dental Questions

What is the reason for today's visit? (Please check all that apply)

Reason		Reason		Reason		Reason	
Pain	Yes No	Sensitive to Hot	Yes No	Sensitive to Cold	Yes No	Sensitive to Biting or Chewing	Yes No

Comments:

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:

X Date:__________