

# MEDICAL HISTORY

1. Have you been an inpatient in the hospital **or** been under the care of a medical doctor during the past two years? .....  YES  NO  
 If yes, for what reason? \_\_\_\_\_

2. Are you **allergic** to ( i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex, epinephrine, or any drugs, medications or any household cleaning products?  YES  NO  
 If yes, please list: \_\_\_\_\_

3. Have you ever been diagnosed with pseudomembranous colitis **or** have you noticed if certain medications give you diarrhea? (name): \_\_\_\_\_  YES  NO

4. Have you ever taken **or** are you currently taking any biphosphonate medications, such as: Zometa, Aredia, Fosamax, Actonel, Boniva, Skelid, Bonefos/Ostac, or Didronel? (name): \_\_\_\_\_  YES  NO

5. Are you on any blood thinning medications? (name): \_\_\_\_\_  YES  NO

6. Check any of the following which you have had or have at present:
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart Failure                      | <input type="checkbox"/> Cancer or Tumor                 | <input type="checkbox"/> HIV Positive (AIDS)            |
| <input type="checkbox"/> Heart Murmur                       | <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> Hepatitis A (infectious)       |
| <input type="checkbox"/> Mitral Valve Prolapse              | <input type="checkbox"/> Cough, Emphysema                | <input type="checkbox"/> Hepatitis B (serum)            |
| <input type="checkbox"/> Artificial Heart Valve             | <input type="checkbox"/> Tuberculosis (TB)               | <input type="checkbox"/> Hepatitis C                    |
| <input type="checkbox"/> Artificial Joint <i>when?</i>      | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Liver Disease                  |
| <input type="checkbox"/> Heart Disease or Attack            | <input type="checkbox"/> Hay Fever                       | <input type="checkbox"/> Kidney Trouble                 |
| <input type="checkbox"/> Angina Pectoris (chest pain )      | <input type="checkbox"/> Sinus Trouble                   | <input type="checkbox"/> Blood Transfusion <i>when?</i> |
| <input type="checkbox"/> High Blood Pressure (hypertension) | <input type="checkbox"/> Allergies or Hives              | <input type="checkbox"/> Drug Addiction                 |
| <input type="checkbox"/> Congenital Heart Lesions           | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Hemophilia                     |
| <input type="checkbox"/> Heart Surgery                      | <input type="checkbox"/> Thyroid Disease                 | <input type="checkbox"/> Cold Sores or Fever Blisters   |
| <input type="checkbox"/> Heart Pacemaker                    | <input type="checkbox"/> X-Ray or Cobalt Treatment       | <input type="checkbox"/> Epilepsy or Seizures           |
| <input type="checkbox"/> Scarlet Fever                      | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Fainting or Dizzy Spells       |
| <input type="checkbox"/> Rheumatic Fever                    | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Nervousness (Excessive)        |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Rheumatism                      | <input type="checkbox"/> Psychiatric Treatment          |
| <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Cortisone Medication            | <input type="checkbox"/> Sickle Cell Disease            |
| <input type="checkbox"/> GERD (reflux)                      | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Bruise Easily                  |
| <input type="checkbox"/> Ulcers                             | <input type="checkbox"/> Pain in Jaw Joints              | <input type="checkbox"/> Bleeding Disorder              |
|   |  | <input type="checkbox"/> <b>NONE OF THE ABOVE</b>       |

7. Do you have any disease, condition or problem not listed? .....  YES  NO

8. Please list all medications you are currently taking.                      NONE                      LIST ATTACHED

\_\_\_\_\_

\_\_\_\_\_

9. Women: Are you Pregnant?  YES  NO *If yes, what month are you due?* \_\_\_\_\_  
 Are you taking birth control pills?.....  YES  NO

♦ **UPON COMPLETION OF ROOT CANAL TREATMENT, I UNDERSTAND THAT I AM TO RETURN TO MY REGULAR DENTIST FOR THE PERMANENT RESTORATION (FILLING AND/OR CROWN).**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_ Initialed: \_\_\_\_\_

\*\* CONTACT PERSON, IN CASE OF AN EMERGENCY: \_\_\_\_\_