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** c-diffcile colitis? 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:

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

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. **Preferred Pharmacy Name & Location:**_____

10. Women: Are you Pregnant? ❑ YES ❑ NO *If yes*, what month are you due?_____
    Are you taking birth control pills? ❑ YES ❑ NO Certain antibiotics may reduce the effectiveness of this medication.

♦ **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: _____**