PATIENT MEDICAL HISTORY

DATE_____

please print

NAME HOME PH. CELL PH.

ADDRESS CITY ZIP

EMPLOYED BY OCCUPATION BUSINESS PH.

DATE OF BIRTH MARITAL STATUS SPOUSE'S NAME

DENTIST PHYSICIAN

		please circle:	
1.	Is your general health good?	Yes	No
2.	Are you currently being treated for any illness?	Yes	No
3.	Are you subject to prolonged bleeding?	Yes	No
	a. Do you take blood thinners (e.g. Aspirin, Coumadin)?	Yes	No
4.	Have you ever taken osteoporosis or cancer medication containing bisphosophonates (e.g. Fosamax, Boniva, Actonel, Evista)?	Yes	No
5.	Have you ever had an allergic reaction to the following:		
	a. Latex	Yes	No
	b. Local Anesthetics (Novocaine)	Yes	No
	c. Penicillin or Amoxicillin	Yes	No
	d. Sulfa Antibiotic	Yes	No
	e. Sedatives (Valium)	Yes	No
	f. Aspirin	Yes	No
	g. Narcotics (Codeine)	Yes	No
	h. Metal (Nickel or other)	Yes	No
	i. Other _____		
6.	Do you normally pre-medicate with antibiotics before routine dental procedures and cleanings?	Yes	No
	If Yes, why?_____		
7.	Have you ever had an orthopedic joint replacement (ex. Hip, Knee)?	Yes	No
	If so, when? _____		
8.	Do you carry with you:		
	a. An epinephrine pen for any allergies?	Yes	No
	b. An inhaler for Asthma?	Yes	No
	c. Insulin if you are diabetic?	Yes	No
	d. Nitroglycerine for chest pain?	Yes	No
9.	Have you taken any recreational drugs (Cocaine, Amphetamines, Marijuana, etc.) in the last 24 hours?	Yes	No
10.	Women only:		
	a. Are you pregnant?	Yes	No
	b. Are you nursing?	Yes	No
	c. Are you taking oral contraceptives?	Yes	No

Do you or have you had any of the following *(please circle)*:

- Dizziness or Fainting Spells
- Epilepsy or Convulsions
- Neurologic Disorders
- Diabetes
- Weak Immune System
- Kidney Disease
- Dialysis
- Liver Disease
- Respiratory Problems (Breathing)
- Tuberculosis
- Asthma
- Thyroid Disease
- Cold Sores or Fever Blister
- Stomach Ulcers or Trouble
- Digestive Problems (Colitis)
- Cancer
- Radiation or Cancer Therapy
- HIV or AIDS
- Hepatitis A or B or C
- Headaches or Migraines
- Glaucoma
- Jaw Problems (TMJ Disorder)
- Drug or Alcohol Dependence
- Psychiatric Care

Do you or have you had any of the following heart or cardiovascular conditions? *(please circle)*:

- Heart Attack
- Stroke
- Angina (Chest Pain)
- Coronary Artery Disease
- High Blood Pressure
- Low Blood Pressure
- Heart Surgery
- Pacemaker or Defibrillator
- Artificial Heart Valves or Stents
- Heart Murmur
- Mitral Valve Prolapse
- Congenital Heart Condition
- Rheumatic Fever (Scarlet)
- History of Infective Endocarditis
- Anemia
- Hemophilia or Bleeding Disorder

(over)

Is there anything else we should know about your medical history?

Please list all your medications (prescription and non-prescription):

AUTHORIZATION AND RELEASE: I certify that I have read, understand and answered the above questions accurately and to the best of my knowledge. I understand that providing incorrect information or withholding information can be dangerous to my health. I will not hold Charlotte Endodontics, or any dentist or staff member working here, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this medical history form.

PATIENT SIGNATURE_____ DATE _____

Doctor's Comments:

DOCTOR SIGNATURE_____ DATE _____