ENDODONTIC SPECIALISTS, P.A.

Endodontic Therapy and Endodontic Microsurgery

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PATIENT HEALTH RECORD

Patient's Name ______________________________

1. Date of birth ______________________________

2. Are you now under the care of a medical doctor? ☐ Yes ☐ No
   Nature of treatment ______________________________

3. Your Medical Doctor's Name ______________________ Phone # ______________________

4. Have you been hospitalized within the past five years? ☐ Yes ☐ No
   Reason ______________________________

5. Do you have or have you had any of the following? (please circle)
   a. Rheumatic fever
   b. Congenital heart disease
   c. Cardiovascular disease: heart attack, irregular heart beat, coronary insufficiency, high blood pressure, arteriosclerosis, stroke, coronary by-pass, prosthetic valve, stent, pacemaker, angina
   d. Allergy: Local anesthetics, penicillin, erythromycin, amoxicillin, tetracycline, sulfa, clindamycin, sedatives, codeine, latex
   e. Asthma, hay fever, sinus trouble
   f. Hives or skin rash
   g. Venereal disease
   h. Diabetes
   i. Hepatitis, jaundice or liver disease
   j. Thyroid condition
   k. Stomach ulcers
   l. Kidney trouble
   m. Tuberculosis, lung disease
   n. Fainting spells or seizures
   o. Psychiatric treatment
   p. Acquired immune deficiency syndrome (HIV positive)
   q. Joint prosthesis (hip, knee, etc.) Date ___________
   r. Heart murmur or mitral valve prolapse

6. Are you taking bisphosphonate medications, i.e. Fosamax, Actonel, Boniva Zometa, Reclast? ☐ Yes ☐ No

7. Are you required to take antibiotics before dental treatment for any medical reason? ☐ Yes ☐ No

8. Have you had any abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No

9. Please list all current medications; including aspirin, herbal or blood-thinning medications

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10. Were you prescribed any medications by your dentist for your dental problem? If so, please list.

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11. (Women) Are you pregnant? ☐ Yes ☐ No

12. (Women) Are you using a prescribed method of birth control? ☐ Yes ☐ No

13. Do you have any disease, condition or problem not listed above? ☐ Yes ☐ No

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Date ____________________ Signature ______________________________