MEDICAL HEALTH HISTORY

Storrs Endodontics & Periodontics

PATIENT NAME: _____

1. Do you have a joint replacement or heart condition which requires antibiotic pre-medication 1 hour prior to EVERY dental appointment? ☐ YES ☐ NO

DOCTOR(S) NAME _____ PHONE(S) _____

2. Are you taking any medication(s) including non-prescription medicine? YES ☐ NO ☐

If yes, what medication(s) are you taking? _____

3. Do you use alcohol, tobacco, or other drugs? YES ☐ NO ☐

4. Are you on any blood thinners? (eg:) Plavix Coumadin Warfarin Aspirin YES ☐ NO ☐

5. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO
Penicillin	☐	☐	**Latex**	☐	☐
Local Anesthetics	☐	☐	**Sedatives**	☐	☐
Sulfa Drugs	☐	☐	**Iodine**	☐	☐
Barbiturates	☐	☐	**Aspirin**	☐	☐

Other Allergies _____

6. WOMEN ONLY

	YES	NO
a) Are you pregnant or think you might be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐
d) Are you taking Bisphosphonates? (eg: Fosamax)	☐	☐

7. Do you have or *have you had* any of the following?

	YES	NO		YES	NO		YES	NO
Heart Attack	☐	☐	Asthma	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Emphysema	☐	☐	Sexually Transmitted Disease	☐	☐
Heart Murmur	☐	☐	Respiratory Problems	☐	☐	Liver Disease	☐	☐
Cardiac Pacemaker	☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Leukemia	☐	☐	Low Blood Pressure	☐	☐
Joint Replacement or Implant	☐	☐	Radiation Treatment	☐	☐	Anemia	☐	☐
IBS	☐	☐	Stroke	☐	☐	Diabetes	☐	☐
Stomach Troubles/Ulcer	☐	☐	Fainting/Seizures	☐	☐	Thyroid Problem	☐	☐
Rheumatic Fever	☐	☐	Epilepsy/Convulsions	☐	☐	Kidney Disease	☐	☐
Angina	☐	☐	Hepatitis	☐	☐	Arthritis	☐	☐
Chest Pains	☐	☐	Jaundice	☐	☐	Hay Fever/Allergies	☐	☐
Arrhythmia	☐	☐	AIDS/HIV Infections	☐	☐	Frequently Tired	☐	☐

COMMENTS _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT, OR GUARDIAN DATE