***Coastal Endodontics***
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## Medical History

Patient's Name_____ Date_____
Date of Birth_____ Sex_____ Physician_____

1. Do you have any of the following conditions that may require antibiotic pre-medication prior to dental treatment?
   a. Artificial heart valve_____ d. Previous infective endocarditis_____
   b. Artificial joint_____ e. Congenital heart disease_____
   c. A cardiac transplant that developed a heart valve problem_____
2. Are you allergic to latex? _____
3. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?_____ If yes, please identify_____
4. Are you on any blood-thinning medications, such as aspirin or coumadin?_____ If yes, please list the medication(s) and dosage(s)_____
5. Are you, or have you recently been, under a physician's care?_____ If yes, please explain_____
6. Have you been an in-patient in the hospital during the past 2 years?_____ If yes, please explain_____
7. Have you ever had any excessive bleeding requiring special treatment?_____ If yes, please explain_____
8. Please list all medications you are currently taking, including aspirins, analgesics and herbal medicines____

   _____

   _____
9. Check any of the following conditions which you have had or have at present:

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

10. Do you have any disease, condition or problem not listed?_____

    _____
11. Contact person, in case of an emergency_____ Phone_____
12. **Women Only:**
    a. Are you pregnant?_____ If yes, what month are you due?_____
    b. Are you breast-feeding?_____
    c. Are you taking birth control pills?_____

Signature_____ Date_____