



Coastal Endodontics

Thomas M. Buttke, Ph.D., D.D.S., P.A.

Kimberly S. Long, D.D.S.

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? Yes _____ No _____
 - a. Artificial heart valve _____
 - b. Artificial joint _____
 - c. A cardiac transplant that developed a heart valve problem _____
 - d. Previous infective endocarditis _____
 - e. Congenital heart disease _____
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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hepatitis A (infectious) |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Cough, Emphysema | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Chemotherapy, (Cancer, Leukemia) | <input type="checkbox"/> Nervousness (Excessive) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> 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 _____

UPDATES TO CONFIDENTIAL MEDICAL HISTORY

Patient's Name _____ Date _____

I have reviewed the Medical History dated _____ and noted the following:

No changes are necessary; all information (including medications) is the same

The following changes in my health have occurred _____

My medications have changed (please explain) _____

Signature of Patient or Guardian

Signature of Assistant / Doctor

Patient's Name _____ Date _____

I have reviewed the Medical History dated _____ and noted the following:

No changes are necessary; all information (including medications) is the same

The following changes in my health have occurred _____

My medications have changed (please explain) _____

Signature of Patient or Guardian

Signature of Assistant / Doctor

Patient's Name _____ Date _____

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