Goodman Goldstein

ENDODONTICS

Medical Information

Name: ____ Date of Birth: ____/____/____ Current Age:_______

All information on this form as well as any additional information provided to your doctor will be held in the strictest confidence. It will not be disclosed to anyone outside this office without your permission. The following questions relate directly to safe and effective dental care. Please answer them honestly to the best of your ability. If you are unsure about a question, or how to answer it, please discuss it with your doctor.

Physician's Name:_______________________________________ Phone: ______________________________

Address: ____ Date of last visit: _____________

Have you ever been hospitalized?____ Yes ____ No. If yes, condition/date: ____________________________

____

Have you taken any medications within the past year?____Yes ____No. If yes, please list all medications and medical conditions being treated: ____

____

____

Are you taking any over the counter medications? ____Yes ____No. If yes, please list: ___________________

____

____

Do you premedicate prior to dental treatment?____ Yes ____ No. If yes, please state reason and medication:

____

Are you taking Coumadin (Warfarin), Plavix, aspirin or any other blood thinners?____Yes ____No

____

Are you taking any Bisphosphonate medications? (Fosamax, Boniva, Actonel, Zometa, Aredia, Skelid, Bonefos, Ostac, Didronel, Loron, Reclast, etc.) ____Yes ____No. If yes, state reason, length of time and in what form - (pills vs. injections):

____

Check any of the following you currently have or have had in the past:

___ Aids
___ Angina
___ Anxiety
___ Arthritis
___ Asthma
___ Bleeding Problems
___ Blood Transfusions
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chronic Cough/Bronchitis
___ Cold Sores
___ Diabetes
___ Drug Addiction
___ Epilepsy or Seizures
___ Fainting/Dizzy Spells
___ Heart Attack
___ Congenital Heart Disease
___ Heart Murmur/Mitral Valve Prolapse
___ Heart Surgery
___ Heart Valve Replacement
___ Hemophilia/Sickle Cell
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ Hepatitis Non A/Non B
___ High Blood Pressure
___ HIV Positive
___ Immunological Disease
___ Injury to Face, Jaw or Teeth
___ Kidney Disease
___ Knee, Hip, etc. Replacements/Implants
___ Liver Disease
___ Pacemaker
___ Pain in Jaw Joints/Dislocation (Clencher, Grinder, Bruxer?)
___ Psychiatric Treatment
___ Radiation Treatment
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Sinus Problems
___ Stroke
___ Thyroid Disease
___ Transplants-kidney, etc.
___ Tuberculosis (TB)
___ Ulcer

(More on Next Page)

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Check any of the following you are allergic to or have had any reactions to:

___ Amoxicillin
___ Anti-Inflammatories
(Motrin, Advil, Aleve, etc.)
___ Antibiotics
___ Aspirin
___ Cephalosporins
___ Codeine
___ Darvon
___ Demerol
___ Erythromycin
___ Latex
___ Local Anesthetic (Lidocaine, etc.)
___ Nitrous Oxide
___ Penicillin
___ Percodan/Percocet
___ Sulfa
___ Tetracycline
___ Tylenol
___ Valium

Are you aware of being allergic to any other medication or substance? ____ Yes ____ No. If yes, please list:
____

Is there anything regarding your medical condition not covered above that you feel the doctor should know about?____Yes ____No. If yes, what?____

WOMEN ONLY

Are you pregnant or planning pregnancy? ____ Yes ____ No. If pregnant, number of weeks: ___________

Obstetrician and Phone: ____

Are you nursing? ____ Yes ____ No Are you taking birth control* at this time? ____ Yes ____ No

*Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please understand an additional form of birth control for one complete cycle will be needed after the course of antibiotics or other medications are completed.

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature:____ Date:_________________

Updated: ________ ________ ________ ________ ________ ________ ________ ________

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AAE American Association of Endodontists
Specialist Members