Rocky Mountain Endodontics

MEDICAL HISTORY

PATIENT NAME: ___________________________________ BIRTH DATE: _____________________________

Rocky Mountain Endodontics is in compliance with latest infection control requirements. This office does not discriminate on the basis of race, sex, national origin, age or disability and we endeavor to protect the privacy of our patients.

Are you under a physician's care now? ☐ **Yes** ☐ **No** If yes, please explain:________________________________

Have you been hospitalized within the last 2 years? ☐ **Yes** ☐ **No** If yes, please explain: ____________________

Are you currently taking any medications? ☐ **Yes** ☐ **No** If yes, please list: ________________________________

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Have you ever taken bisphosphonate medications such Fosamax, Actonel or Zometa? ☐ **Yes** ☐ **No**

Do you use any controlled substances ☐ **Yes** ☐ **No**

Women: Are you

Pregnant/Trying to get pregnant? ☐ **Yes** ☐ **No** Taking oral contraceptives? ☐ **Yes** ☐ **No**

Nursing ☐ **Yes** ☐ **No**

Are you allergic to any of the following?

☐ Penicillin/ Amoxicillin ☐ Clindamycin ☐ Erythromycin ☐ Keflex ☐ Aspirin ☐ Codeine

☐ Epinephrine ☐ Nitrous Oxide ☐ Lidocaine(Xylocaine) ☐ Latex ☐ Sulfa

☐ Other: ______________________________________

Do you have, or have you had any of the following?

High Blood Pressure	☐ **Yes** ☐ **No**	Heart Valve Replacement	☐ **Yes** ☐ **No**
Heart Attack	☐ **Yes** ☐ **No**	Mitral Valve Prolapse	☐ **Yes** ☐ **No**
Heart Surgery	☐ **Yes** ☐ **No**	Rheumatic Fever	☐ **Yes** ☐ **No**
Angina	☐ **Yes** ☐ **No**	Heart Murmur	☐ **Yes** ☐ **No**
Cold Sores	☐ **Yes** ☐ **No**	Stroke	☐ **Yes** ☐ **No**
Diabetes	☐ **Yes** ☐ **No**	Asthma	☐ **Yes** ☐ **No**
Stomach Ulcers	☐ **Yes** ☐ **No**	Kidney Problems	☐ **Yes** ☐ **No**
Liver Disease	☐ **Yes** ☐ **No**	Tuberculosis	☐ **Yes** ☐ **No**
Fainting Spells	☐ **Yes** ☐ **No**	Excessive Bleeding	☐ **Yes** ☐ **No**
Glaucoma	☐ **Yes** ☐ **No**	Hepatitis A,B,C	☐ **Yes** ☐ **No**
Vertigo	☐ **Yes** ☐**No**		

Blood Disease (Leukemia, AIDS, HIV, Anemia)…………………………………………. ☐ **Yes** ☐ **No**

Have you ever had any serious illness not listed above? ☐ **Yes** ☐ **No**

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian:______________________________________**Date:**_________________

Reviewed By Doctor:____**Date:**_________________