Time 10:46 AM | Advanced Endodontics Of Bucks County | Date 5/9/2016

Dental/Medical History(Copy)

Patient Name: | Birth Date: | Date Created:

Who is your general dentist?

Are you currently under a physician's care now? ◯ Yes ◯ No If yes

Have you recently been hospitalized or had a major operation? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs?

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ◯ Yes ◯ No If yes

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Renal Dialysis	☐ Anemia
☐ Herpes	☐ Rheumatic Fever	☐ Angina	☐ Emphysema
☐ High Blood Pressure	☐ Arthritis/Rheumatism	☐ Epilepsy or Seizures	☐ High Cholesterol
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Asthma
☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Blood Disease	☐ Frequent Cough
☐ Kidney Problems	☐ Spina Bifida	☐ Blood Transfusion	☐ Leukemia
☐ Stomach/Intestinal Disease	☐ Breathing Problems	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Low Blood Pressure	☐ Swelling of Limbs/Gout	☐ Cancer
☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease	☐ Chemotherapy
☐ Mitral Valve Prolapse	☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis
☐ Tuberculosis	☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints
☐ Tumors or Growths	☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease
☐ Ulcers	☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____