Essential Endodontics

MEDICAL HISTORY

Today's Date _____ Birthdate _____ ☐Female ☐ Male

Name _____
Last First Middle

Please indicate all conditions which apply to you past or present:

☐ Asthma	☐ Stroke	☐ Thyroid disorder	☐ Kidney disease
☐ Allergies	☐ Heart disease	☐ Tuberculosis	☐ Liver disease
☐ Sinus problems	☐ Mitral valve prolapse	☐ Lung disease	☐ Cancer
☐ Arthritis	☐ Heart murmur	☐ Immune disorder	☐ Mental illness
☐ High blood pressure	☐ Pace maker	☐ Ulcers	☐ Anxiety/Depression
☐ High Cholesterol	☐ Seizures/epilepsy	☐ Headaches	☐ Alcoholism
☐ Diabetes	☐ Bleeding/clotting disorder	☐ Osteoporosis	☐ Substance abuse

Current Medications (including supplements and over the counter medication)	**Reason**

Do you take osteoporosis medication? ☐ Yes ☐ No If yes, how long? _____
Please list all Surgeries including Artificial Joints (year) _____
_____
Do you require antibiotics prior to dental treatment due to heart condition or artificial joint? ☐ Yes ☐ No
If yes, What type of antibiotics and when did you take it? _____
Are you allergic to ☐ Latex, ☐ Dye, ☐ medication _____

Tobacco Usage: ☐ Never ☐ Quit: Year quit _____ ☐ Current user Smokeless/Cigarettes/Cigars/Pipe
#Packs/day ____# years ____ ☐ I am not ready to quit ☐ I am currently in a cessation program ☐ I would like information on quitting

Alcohol Use: ☐None ☐ Occasional ☐ In Recovery

Women: Do you think you might be pregnant? ☐ Yes ☐No

Dental History

Reason for your visit today _____
History of this tooth (fillings, crowns, Previous Root canal etc) _____
_____
Please indicate all conditions which apply:

☐ Toothache	☐ Pain to Cold	☐ Cavities
☐ Gum disease	☐ Pain to Heat	☐ Abscess in mouth
☐ Sensitive gums	☐ Pain on Chewing	☐ Grinding/Clenching
☐ Sensitive teeth	☐ Pain on release	☐ Pain in Jaw/TMD

Do you have special concerns regarding your visit? ☐ Fear ☐Time ☐ Money ☐ Stress

Is there anything you would like to discuss with Dr. Adu-Sarkodie in private? ☐YES ☐ NO

I certify that the above is accurate and that I am responsible to notify this office of any changes in my health:

_____ _____
Signature Patient or Patient Representative Date

_____ _____
Dr. Signature Date