endodontic associates, ltd.
Dr. James R. Granite • Dr. Frederic H. Siegal • Dr. Francine T. Cwyk

PATIENT MEDICAL HISTORY

1. Are you currently being treated by your physician for any medical condition? _____
_____

2. Physician's Name _____

3 .Please list ALL medications you are currently taking: _____

_____

4. Please circle any illness you have ever had:

heart valve replacement	high blood pressure	joint replacement	allergies to medicine
heart murmur	heart trouble	infectious hepatitis	sinus problems
mitral valve prolapse	anemia	tuberculosis	asthma
rheumatic fever	diabetes	epilepsy/seizures	AIDS (HIV)
psychological	glaucoma	kidney/liver	thyroid
Crohn's disease	irritable bowel/colitis	TMJ/TMD	

5. Has a dentist or a physician ever told you that you need to take antibiotics before dental appointments for a medical condition ? No …. Yes … If yes, have you taken them today? No…. Yes….
What did you take?_____ How much?_____

6. Have you had knee, hip or other joint replacement? No… Yes …….. If so, when?_____

7. Have you ever taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or Phen-fen (fenfluramine-phentermine combination)? No… Yes….. If so, when? _____
Have you seen your physician about this? No… Yes…… If so, when ?_____

8. Do you wear a pacemaker? No….. Yes…..

9. Have you ever had trouble with prolonged bleeding after surgery? No…. Yes….

10 . Do you take blood thinners such as Plavix (clopidoqrel), Coumadin (warfarin), Asprin ? N o… Yes..

11. Are you currently taking or have you taken bisphophonate medications, such as Actonel, Fosamax or Zometa, within the past 12 years? No….. Yes…….. If so, which one? _____

12. Please circle any of the medications or substances listed below to which you have had an unusual reaction:

Penicillin	Clindamycin (Cleocin)	Ibuprofen/Advil/Motrin	Codeine	Latex
Aspirin	Adrenaline (Epinephrine)	Tylenol	Sulfa	
Novocaine	Erythromycin		Others : please list below	

_____

12. Is there any other information that we should be know about your health? Any chronic conditions?
_____

13. Is there any information that you would like to tell us about previous dental appointments?
_____

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I will not hold Endodontic Associates, LTD or any members of their dental team responsible for errors or omissions that I have made in completion of this form It is my responsibility to notify my dentist of any changes in the above medical status.

Patient or Responsible Party Signature:_____ Date:_____