Tirrell Endodontics

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MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your conditions. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur. We as well will ask you to update this medical history if it has been over a year since we last saw you. Thank you.

Patient Name: _____ Date of Birth: _____

Preferred Name: _____ **YES** **NO**

1. Has there been any change in your general health within the past year?..... ☐ ☐
   Please specify: _____
2. Are you under the care of a physician for a current problem?..... ☐ ☐
   Reason: _____
3. Have you been hospitalized within the past five years?..... ☐ ☐
   Reason: _____
4. Are you taking any medications or drugs?..... ☐ ☐
   Please specify: _____
5. Do you have a history of drug or alcohol abuse?..... ☐ ☐
6. Have you received therapy for alcoholism or drug addiction during the past five years?..... ☐ ☐
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics, antibiotics, or other medications, or **LATEX**?..... ☐ ☐
   Please specify: _____
8. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?..... ☐ ☐
9. Have you ever required a blood transfusion?..... ☐ ☐
   Please explain: _____
10. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?..... ☐ ☐
11. Have you ever been tested for HIV infections (AIDS)?..... ☐ ☐
    Result of test: ☐ Positive ☐ Negative
12. Date of last physical exam: _____
13. Do you have or have had any of the following (please check):

☐ High blood pressure	☐ Sinus trouble	☐ Heart murmur or prolapsed valve (MVP)
☐ Thyroid problems	☐ Diabetes	☐ Joint prosthesis (hip, knee, etc.)
☐ Stomach ulcers, colitis	☐ Kidney problems	☐ Jaundice, Liver disease
☐ Psychiatric treatment	☐ Fainting spells or seizures	☐ Blood disorder (e.g. anemia)
☐ Prosthetic heart valve	☐ Venereal disease	☐ Asthma
☐ Epilepsy	☐ Cancer	☐ Pacemaker
☐ Lung disease/TB	☐ Congenital heart disease	☐ Hepatitis B
☐ Temporomandibular joint problems (TMJ)		☐ Hepatitis C

☐ Rheumatic fever or rheumatic heart disease ☐ cardiovascular disease: heart attack, stroke, by-pass

14. Do you have any disease, conditions or problems not listed above?..... ☐ ☐
    Please specify: _____
15. Are you required to take antibiotics, **in regards to a medical condition**, prior to dental treatment?..... ☐ ☐

16. Are you pregnant?..... ☐ ☐
17. Are you nursing?..... ☐ ☐
18. Do you take birth control pills?..... ☐ ☐

If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist.

_____ _____

Date Signature of Patient*

*All signatures must be by parent or guardian if patient is under the age of 18.