Coastal Endodontics
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Medical History

Patient's Name_____ Date_____
Date of Birth_____ Sex_____ Physician_____

1. Do you have any of the following conditions that may require antibiotic pre-medication prior to dental treatment? Yes _____ No _____
   a. Artificial heart valve_____ b. Previous infective endocarditis_____
   c.. Artificial joint_____ d. Congenital heart disease_____
   e. A cardiac transplant that developed a heart valve problem_____
2. Are you anxious prior to dental treatments? _____
3. Are you allergic to latex? _____
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?_____ If yes, please identify_____
5. Are you on any blood-thinning medications, such as aspirin or coumadin?_____ If yes, please list the medication(s) and dosage(s)_____
6. Are you, or have you recently been, under a physician's care?_____ If yes, please explain_____
7. Have you been an in-patient in the hospital during the past 2 years?_____ If yes, please explain_____
8. Have you ever had any excessive bleeding requiring special treatment?_____ If yes, please explain_____
9. Please list all medications you are currently taking, including aspirins, analgesics and herbal medicines
   _____
   _____
10. Check any of the following conditions which you have had or have at present:

☐ Heart Failure	☐ Cancer or Tumor	☐ HIV Positive
☐ Heart Murmur	☐ Shortness of Breath	☐ Hepatitis A (infectious)
☐ Mitral Valve Prolapse	☐ Cough, Emphysema	☐ Hepatitis B (serum)
☐ Artificial Heart Valve	☐ Tuberculosis (TB)	☐ Liver Disease
☐ Artificial Joint	☐ Asthma	☐ Yellow Jaundice
☐ Heart Disease or Attack	☐ Hay Fever	☐ Blood Transfusion
☐ Angina Pectoris (chest pain)	☐ Sinus Trouble	☐ Drug Addiction
☐ High Blood Pressure	☐ Allergies or Hives	☐ Hemophilia
☐ Congenital Heart Lesions	☐ Diabetes	☐ Cold Sores or Fever Blisters
☐ Heart Surgery	☐ Thyroid Disease	☐ Epilepsy or Seizures
☐ Heart Pacemaker	☐ X-Ray or Cobalt Treatment	☐ Fainting or Dizzy Spells
☐ Scarlet Fever	☐ Chemotherapy (Cancer, Leukemia)	☐ Nervousness (Excessive)
☐ Rheumatic Fever	☐ Arthritis	☐ Psychiatric Treatment
☐ Anemia	☐ Rheumatism	☐ Sickle Cell Disease
☐ Stroke	☐ Cortisone Medication	☐ Bruise Easily
☐ Kidney Trouble	☐ Glaucoma	☐ Bleeding Disorder
☐ Ulcers	☐ Pain in Jaw Joints	☐ NONE OF THE ABOVE

11. Do you have any disease, condition or problem not listed?_____
    _____
12. Contact person, in case of an emergency_____ Phone_____
13. **Women Only:**
    a. Are you pregnant?_____ If yes, what month are you due?_____
    b. Are you breast-feeding?_____
    c. Are you taking birth control pills?_____

Signature_____ Date_____