Medical History

Patient's Name: _____ Preferred Name: _____

Occupation: _____ General Dentist: _____

Physician: _____ Medical Specialist: _____

Please *circle* the applicable answer. This information is used to assess the impact your health history may have on any treatment recommended.

1. Are you having pain or discomfort at this time?..... Yes No
2. Do you feel nervous about having dental treatment? ..... Yes No
3. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax or Zometa within the past 12 years?..... Yes No
4. In the last 24 hours have you used Cocaine, Ecstasy or Methamphetamines?..... Yes No
5. Do you have or have you ever had any of the following (please circle)?

High Blood Pressure	Hepatitis	Bleeding Disorder	Heart Attack
Coronary Bypass	Jaundice	Glaucoma	Arrythmias
Liver Disorders	Chemical Dependency	Pacemaker	Asthma
Alcoholism	Stroke	Respiratory Problems	Anemia
Heart Defect	Diabetes	Kidney Problems	Heart Murmur
Epilepsy	Venereal Disease	Mitral Valve Prolapse	Osteoporosis
Tuberculosis	Heart Valve Replacement	Herpes	Arthritis
Artificial Joint	AIDS/HIV Positive	Psychiatric Treatment	Blood Transfusion
Rheumatic Fever	Ulcers	Hemophilia	Cancer

6. Have you had/do you have any other serious medical condition not listed above? …… Yes No
   If yes, please describe: _____
7. Do you have any allergies or sensitivities to the following:

Penicillin	Erythromycin	Tetracycline	Sulfa	Demerol
Percodan	Aspirin	Valium	Codeine	Latex

Local Anesthetic or other (please list): _____

8. **Are you taking any drugs or medications now? If YES, please list ALL including herbal remedies such as St. John's Wort and over the counter medications?** _____
   _____
9. Have you ever had an unfavorable reaction to dental treatment? …… Yes No
   If yes, please describe _____
10. Do you premedicate with antibiotics prior to ALL dental appointments?..... Yes No
    If yes, what do you take? _____
11. Have you ever had excessive bleeding requiring special treatment? …… Yes No
    If yes, please describe _____
12. **FEMALE PATIENTS**: Are you trying to conceive, pregnant or nursing? …… Yes No
    Do you take birth control pills? …… Yes No

Please read and sign below:

I authorize Dr. Maguire to consult with my physician(s) or other health professionals to seek clarification on the effect of my previous or present medical or dental condition on any proposed endodontic treatment. I also authorize and request Dr. Maguire to perform an endodontic examination and any such tests/x-rays/scans as required. To avoid any misunderstandings regarding dental insurance, we want our patients to know that all professional services are charged directly to the patient and that the patient is PERSONALLY responsible for payment of fees. Upon complete payment of fees, we will prepare the necessary forms to help you obtain your insurance benefits. WE DO NOT RENDER SERVICES ON THE BASIS THAT INSURANCE COMPANIES WILL PAY OUR FEES.

Date: _____ **Signed:** _____

Review and initial when updated at return visits: _____ **Date:** _____