GATEWAY
ENDODONTICS

MEDICAL HISTORY

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

Dental History

Have you ever had a root canal treatment before? ☐ Yes ☐ No

If so, has the tooth we are evaluating today had root canal treatment? ☐ Yes ☐ No

Have you had any recent dental treatment on the tooth we are evaluating today? ☐ Yes ☐ No

If so, please describe: _____

Briefly describe your symptoms: _____

Medical History

Physician's Name: _____

Address: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, for what reason? _____

Are you presently taking any medications/drugs/pills? ☐ Yes ☐ No

Have you or anyone in your family had an adverse reaction to local anesthesia, IV sedation, or general anesthesia? ☐ Yes ☐ No

Is there anything you would like to discuss privately with the Dentist? ☐ Yes ☐ No

RICHARD ORRICK, DMD, MSD

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Medications

List prescriptions {including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances. Include dosages if available.

Medications

Are you allergic/ sensitive (or ever had an adverse reaction) to: Check all that apply or check none

☐ Penicillin ☐ Local Anesthetic ☐ Codeine ☐ Metals ☐ Latex

☐ Aspirin ☐ Other Antibiotics ☐ None ☐ Other Medications or Substances: _____

Bisphosphonates

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibrandronate (Boniva®) for osteoporosis or Paget's disease?

☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date treatment began: ☐ Yes ☐ No

Comments

Have you ever used or currently use tobacco products? ☐ Yes ☐ No

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew How long ago did you quit? _____

How much? _____ How often? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

How much? _____ How often? _____

Have you had any other serious illness, hospitalization or accident? ☐ Yes ☐ No

If yes, please explain: _____

WOMEN: Are you pregnant or suspect that you may be? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

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Do you have, or have you ever had any of the following: (YES OR NO)

1. Artificial (prosthetic heart valve) ☐ Yes ☐ No
2. Previous infective endocarditis ☐ Yes ☐ No
3. Damaged valves in transplanted heart ☐ Yes ☐ No
4. Congenital heart disease (CHD)
   - Unrepaired, cyanotic CHD ☐ Yes ☐ No
   - Repaired (completely) in last 6 months ☐ Yes ☐ No
   - Repaired CHD with residual defects ☐ Yes ☐ No
5. Heart Disease/Surgery ☐ Yes ☐ No
6. Heart murmur ☐ Yes ☐ No
7. Heart pacemaker ☐ Yes ☐ No
8. Rheumatic fever/heart disease ☐ Yes ☐ No
9. Mitral valve prolapse ☐ Yes ☐ No
10. High/low blood pressure ☐ Yes ☐ No
11. Learning Disability ☐ Yes ☐ No
12. Mental Health Disorder ☐ Yes ☐ No
13. Anorexia ☐ Yes ☐ No
14. Bulimia ☐ Yes ☐ No
15. Lung disease/COPD ☐ Yes ☐ No
16. Tuberculosis ☐ Yes ☐ No
17. Asthma ☐ Yes ☐ No
18. Shortness of Breath ☐ Yes ☐ No
19. Respiratory Ailments ☐ Yes ☐ No
20. Emphysema ☐ Yes ☐ No
21. Sinus Trouble ☐ Yes ☐ No
22. Diabetes Type I or Type II ☐ Yes ☐ No
23. Thyroid Problems ☐ Yes ☐ No
24. Persistent swollen glands ☐ Yes ☐ No
25. Kidney Problems ☐ Yes ☐ No
26. Venereal Disease ☐ Yes ☐ No
27. HIV Positive/AIDS/ARC ☐ Yes ☐ No
28. Alcohol Addiction ☐ Yes ☐ No
29. Drug Dependency ☐ Yes ☐ No
30. Chemical Dependency ☐ Yes ☐ No
31. Blood Disorders ☐ Yes ☐ No
32. Anemia ☐ Yes ☐ No
33. Leukemia ☐ Yes ☐ No
34. Prolonged Bleeding ☐ Yes ☐ No
35. Hemophilia ☐ Yes ☐ No
36. Sickle Cell Disease ☐ Yes ☐ No
37. Cancer ☐ Yes ☐ No
38. Tumors ☐ Yes ☐ No
39. Chemotherapy ☐ Yes ☐ No
40. Radiation Therapy ☐ Yes ☐ No
41. Neurological Disorders ☐ Yes ☐ No
42. Epilepsy ☐ Yes ☐ No
43. Stroke ☐ Yes ☐ No
44. Arthritis / Rheumatism ☐ Yes ☐ No
45. Autoimmune Disease ☐ Yes ☐ No
46. Artificial Joint / Prosthesis ☐ Yes ☐ No
47. Liver Disease ☐ Yes ☐ No
48. Hepatitis (select one) ☐ Yes ☐ No
    Type: ☐A ☐B ☐C ☐Other
49. Ulcers ☐ Yes ☐ No
50. Gastrointestinal Disease ☐ Yes ☐ No
51. GERD (gastric reflux) ☐ Yes ☐ No
52. Deaf or Hard of Hearing ☐ Yes ☐ No
53. Glaucoma ☐ Yes ☐ No
54. Cortisone Medication ☐ Yes ☐ No
55. Fainting Spells ☐ Yes ☐ No
56. Organ Transplant ☐ Yes ☐ No
57. Removal of Spleen ☐ Yes ☐ No
58. Osteoporosis ☐ Yes ☐ No
59. Sleep Disorder ☐ Yes ☐ No
60. Elevated Cholesterol ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Name: _____ Date: _____

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