Endodontic Associates of Weymouth

1650 Main Street, S. Weymouth, MA 02190, Tel. (781) 206-2660

Patient Name: Dr/Mr/Mrs/Ms_____ Date: _____
LAST FIRST MI

E-mail: _____

Address: _____ City: _____ State: __ Zip: _____

Phone No: Home: _____ Cell: _____ Work: _____

Gender: M / F Birth date: _____ Social Security No: _____

General Dentist's Name: _____ Phone No: _____

List any immediate family members treated at this office: _____

Emergency Contact Name: _____ Phone No: _____

MEDICAL HISTORY

Primary Physician's Name: _____ Telephone: _____

Address: _____

Last Physical Exam: _____

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Under a physician's care now? Y☐ N☐

Any hospitalization in the past 5 years? Y☐ N☐_____

Any serious illnesses/surgeries? Y☐ N☐_____

Use tobacco in any form? Y☐ N☐ If Yes, Type: _____

Is pre-medication required before dental visits due to heart condition or artificial joint? Y☐ N☐

FEMALE PATIENTS: Currently nursing? Y☐ N☐ Currently pregnant? Y☐ N☐ Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? Y☐ N☐

If yes, please describe:_____

Is there anything important about your medical condition we have not asked? Y☐ N☐ If yes, please describe: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE ☐

☐Acid reflux	☐Cancer/Malignancy	☐Hay fever	☐Pacemaker
☐ADHD	☐Chemical dependency	☐Hearing problems	☐Parathyroid condition
☐AIDS/HIV	☐Chicken pox	☐Heart attack	☐Psychiatric treatment
☐Anemia	☐Convulsions	☐Heart disease	☐Radiation/Chemo
☐Anorexia	☐Congenital heart disease	☐Heart murmur	☐Respiratory disease
☐Anxiety	☐Depression	☐Hepatitis	☐Rheumatic/Scarlet fever
☐Artificial heart valve	☐Diabetes	☐High/Low blood pressure	☐Sinus problems
☐Artificial joints	☐Dizziness/Fainting	☐High cholesterol	☐Sickle cell disease
☐Arthritis/Gout	☐Epilepsy/Seizures	☐Hives/Rash	☐Shingles
☐Asthma	☐Frequent ear infections	☐Irregular heart beat	☐Stroke
☐Autism/Asperger's	☐Frequent headaches	☐Kidney disease	☐Thyroid condition
☐Bleeding disorder	☐Frequent cough	☐Liver disease	☐Tuberculosis
☐Blood transfusions	☐Frequent Diarrhea	☐Mitral valve prolapse	☐Ulcers/Colitis
☐Bulimia	☐Fever blisters/Herpes	☐Mononucleosis	☐Venereal disease
☐Bruise easily	☐Glaucoma	☐Osteoporosis	☐Other-Please list:

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): NONE ☐

☐Acrylic	☐Codeine	☐Metal	☐Penicillin
☐Aspirin	☐Dairy	☐Nitrous oxide	☐Other antibiotics
☐Anesthetic-local	☐Latex	☐Sleeping pills	☐Other-Please list:
☐Barbiturates	☐Lactose intolerance	☐Sulfa drugs	

Do you take or have you taken Phen-Fen or Redux? Y☐ N☐

Have you ever taken Fosamex, Bonivia, Actonel or any other medications containing bisphosphonates? Y☐ N☐

ARE YOU CURRENTLY TAKING PRESCRIPTION OR DAILY OTC MEDICATIONS INCLUDING, BUT NOT LIMITED TO ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE ☐

☐Antibiotics/Sulfa drugs	☐Antihistamines/Allergy	☐Daily Aspirin	☐Blood pressure meds
☐Blood thinners	☐Cancer/Chemo meds	☐Cortisone/Steroids	☐Heart meds/Digitalis
☐Insulin	☐Nitroglycerin	☐Oral contraceptives	☐Osteoporosis meds
☐Other Diabetic medications	☐Recreational drugs	☐Thyroid medications	☐Tranquilizers
			☐Other-Please list

*Patients on **BIRTH CONTROL PILLS** must aware that antibiotics (and some other medications) may interfere with the effectiveness of birth control pills. Therefore, please consult with your physician regarding other methods of birth control.*

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status and/or if my medication changes, I shall inform the dentist and staff at the next appointment without fail. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Signature: _____Date: _____

If this is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____ Doctor's initials: _____