Essential Endodontics

# MEDICAL HISTORY

Today's Date _____ Birthdate _____Sex_____

Name _____
Last First Middle

**Please indicate all conditions which apply to you past or present:**

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Stroke | ☐ Thyroid disorder | ☐ Gallbladder |
| ☐ Allergies | ☐ Heart disease | ☐ Tuberculosis | ☐ Liver disease |
| ☐ Sinus problems | ☐ Mitral valve prolapse | ☐ Lung disease | ☐ Kidney disease |
| ☐ Arthritis | ☐ Heart murmur | ☐ Immune disorder | ☐ Cancer |
| ☐ High blood pressure | ☐ Pace maker | ☐ Ulcers | ☐ Mental illness |
| ☐ High Cholesterol | ☐ Seizures/epilepsy | ☐ Headaches | ☐ Alcoholism |
| ☐ Diabetes | ☐ Bleeding/clotting disorder | ☐ Osteoporosis | ☐ Substance abuse |

**Women:** Do you think you might be pregnant? ☐ YES ☐NO
Do you require antibiotics prior to dental treatment due to heart condition or artificial joint? ☐ YES ☐NO
Type of antibiotic, dose and time _____

**SURGERIES (year or age):** ☐ NONE _____
Artificial Joints _____ Date _____
**CURRENT MEDICATIONS: Prescription Medications**: ☐ NONE _____
_____
Do you take osteoporosis medication? ☐ YES ☐NO How many years? _____
List all **Non-Prescription Medications** you take regularly (supplements, vitamins, antacids, pain meds, etc.)
_____

**ALLERGIES:** ☐ NONE ☐ Bee Sting ☐ Poison Oak ☐ Latex ☐ Dye
☐ Medication: _____

**Tobacco Usage**: ☐ None ☐ Quit Year quit _____ ☐ Current use #Packs/day _____# years _____
☐ I am currently in a cessation program ☐ I would like information on quitting ☐ I am not ready to quit
**Alcohol Use**: ☐None ☐ In Recovery ☐ Occasional/Rarely ☐ Weekly ☐ Daily # drinks per day/week _____
☐ I would like information on quitting alcohol

## Dental History

Please indicate all conditions which apply to this tooth:

| | | |
|---|---|---|
| ☐ Toothache | ☐ Cold sensitivity | ☐ Cavities |
| ☐ Gum disease | ☐ Hot sensitivity | ☐ Abscess in mouth |
| ☐ Sensitive gums | ☐ Chewing Sensitivity | ☐ Grinding/Clenching |
| ☐ Crown | ☐ Previous Root canal | ☐ Pain in Jaw/TMD |

Reason for your visit today _____

Do you have special concerns regarding your visit? ☐ Fear ☐Time ☐ Money ☐ Stress

Is there anything you would like to discuss with Dr. Adu-Sarkodie in private? ☐YES ☐ NO

I certify that the above is accurate and that I am responsible to notify this office of any changes in my health

_____ _____
Signature Patient or Patient Representative Date

_____ _____
Dr. Signature Date

12711 McGregor Boulevard, Fort Myers, FL 33919 Phone (239) 728-endo Fax (239) 693-3637