micro
ENDODONTICS
Practice Limited to Endodontics

PLEASE PRINT & COMPLETE ALL FIELDS
TO THE BEST OF YOUR ABILITY.

ANDOVER LOCATION
+1 (978) 475-8008
+1 (978) 475-9990

PATIENT MEDICAL HISTORY

MICRO ENDODONTICS CONFIDENTIAL PATIENT INFORMATION

BOSTON LOCATION
+1 (617) 366-1600
+1 (617) 366-1700

Patients Name: ______ Date: ______

Name of Physician: ______ Phone: ______

Date of Last Visit: ______ Reason for Last Visit: ______

Your current physical health is? ☐ GOOD ☐ FAIR ☐ POOR

Are you taking any medications? ☐ YES ☐ NO

If yes, please list: ______

Have you ever taken Phen-Fen, Redux, or Pondimin? ☐ YES ☐ No If yes, when? ______

Are you currently taking aspirin? ☐ YES ☐ NO Are you taking herbal supplements? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Week #: ______ Are you on birth control? ☐ YES ☐ NO

Have you ever had any of the following diseases or medical problems?

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
AIDS	☐ YES	☐ NO	Drug Abuse	☐ YES	☐ NO	Knee Replacement	☐ YES	☐ NO
Alcohol Abuse	☐ YES	☐ NO	Emphysema	☐ YES	☐ NO	Joint Replacement	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Fainting	☐ YES	☐ NO	Mitral Valve Prolapse	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Heart Attack	☐ YES	☐ NO	Pacemaker	☐ YES	☐ NO
Bleeding Problems	☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO	Radiation Treatment	☐ YES	☐ NO
Blood Transfusion	☐ YES	☐ NO	Heart Surgery	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Breathing Problems	☐ YES	☐ NO	Heart Valve Replacement	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Cancer/Chemotherapy	☐ YES	☐ NO	Hemophilia	☐ YES	☐ NO	Sinus Problems	☐ YES	☐ NO
Colitis	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO	Steroid Therapy	☐ YES	☐ NO
Congenital Heart Defect	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Subacute Bact Endocarditis	☐ YES	☐ NO
Defibrillator	☐ YES	☐ NO	Hip Replacement	☐ YES	☐ NO	Thyroid Treatment	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	HIV	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Dizzy Spells	☐ YES	☐ NO	Kidney Problems	☐ YES	☐ NO	Other? Please specify	☐ YES	☐ NO

Do you have any other medical conditions? If so, please list: ______

Have you had any recent hospitalizations? If so, when? ______

Are you allergic to any of the following:

Allergen	YES	NO	Allergen	YES	NO	Allergen	YES	NO
Aspirin	☐ YES	☐ NO	Local anesthesia	☐ YES	☐ NO	Penicillin	☐ YES	☐ NO
Codeine	☐ YES	☐ NO	Latex	☐ YES	☐ NO	Other antibiotics	☐ YES	☐ NO

Please list any other drugs or materials you are allergic to: ______

1st UPDATE Any changes? ______ Date: ______

Patient/guardian signature ______ Reviewed by doctor ______ Date ______