NORTH BRIDGE ENDODONTICS
Andy M. Ashtiani D.D.S., M.S., F.A.D.S.A.

Submit Clear Form Print Form

MEDICAL HISTORY FORM

Name _____
LAST FIRST MI

Height_____ Weight _____

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

For the following questions, circle *yes* or *no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? . . . . . Yes No
2. Have there been any changes in your health within the past year? . . . . . Yes No
3. My last physical examination was on _____
4. Are you under the care of a physician? . . . . . Yes No
   If so, what is the condition being treated? _____
5. The Name and address of my physician is _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? . . . . . Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? . . . . . Yes No
   If so, what medicine(s) are you taking? _____
   _____
   _____
8. Has your physician ever told you to take antibiotics prior to dental therapy for a medical condition? . . . . . Yes No
9. Have you taken Fen-phen? . . . . . Yes No
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? . . . . . Yes No
    b. Cardiovascular disease, heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke . . . . . Yes No
        1. Do you have chest pain upon exertion . . . . . Yes No
        2. Are you ever short of breath after mild exercise or when lying down? . . . . . Yes No
        3. Do your ankles swell? . . . . . Yes No
        4. Do you have inborn heart defects? . . . . . Yes No
        5. Do you have a cardiac pacemaker? . . . . . Yes No
    c. Allergy . . . . . Yes No
    d. Sinus trouble . . . . . Yes No
    e. Asthma or hay fever . . . . . Yes No
    f. Fainting spells or seizures . . . . . Yes No
    g. Persistent diarrhea or recent weight loss . . . . . Yes No
    h. Diabetes . . . . . Yes No
    i. Hepatitis, jaundice or disease . . . . . Yes No
    j. AID, HIV infection, ARC, or Lupus . . . . . Yes No
    k. Thyroid problems . . . . . Yes No

OTHER SIDE →

l. Respiratory problems . . . . . Yes ○ No ○
m. Arthritis or painful swollen joints . . . . . Yes ○ No ○
n. Stomach ulcer or hyperactivity . . . . . Yes ○ No ○
o. Kidney trouble . . . . . Yes ○ No ○
p. Tuberculosis . . . . . Yes ○ No ○
q. Persistent cough or cough that produces blood . . . . . Yes ○ No ○
r. Persistent swollen glands in neck . . . . . Yes ○ No ○
s. Low blood pressure . . . . . Yes ○ No ○
t. Sexually transmitted disease . . . . . Yes ○ No ○
u. Epilepsy or other neurological disease . . . . . Yes ○ No ○
v. Problems with mental health . . . . . Yes ○ No ○
w. Cancer . . . . . Yes ○ No ○
x. Problems with immune system . . . . . Yes ○ No ○

11. Have you had abnormal bleeding? . . . . . Yes ○ No ○
    a. Have you ever required a blood transfusion?
12. Do you have any blood disorder such as anemia? . . . . . Yes ○ No ○
13. Have you ever had any treatment for a tumor or growth? . . . . . Yes ○ No ○
14. Are you allergic or have you had a reaction to:
    a. Local anesthetics . . . . . Yes ○ No ○
    b. Penicillin or other antibiotics . . . . . Yes ○ No ○
    c. Sulfa drugs . . . . . Yes ○ No ○
    d. Barbiturates, sedatives, sleeping pills or valium . . . . . Yes ○ No ○
    e. Aspirin, Ibuprofen, Advil or Tylenol . . . . . Yes ○ No ○
    f. Iodine . . . . . Yes ○ No ○
    g. Codeine, Vicodin, Demerol or other narcotics . . . . . Yes ○ No ○
    h. Latex Allergy . . . . . Yes ○ No ○
    i. Other . . . . . Yes ○ No ○
15. Have you had any serious trouble associated with any previous dental treatment surgery or previous anesthetic? . . . . . Yes ○ No ○
    If so, explain _____
16. Has anyone in your family had a bad reaction to any anesthetic? . . . . . Yes ○ No ○
    If so, explain _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . Yes ○ No ○
18. Are you wearing contact lenses? . . . . . Yes ○ No ○
19. Are you wearing removable dental appliances? . . . . . Yes ○ No ○
20. Do you have TMJ (Temporal Mandibular Joint) Symptoms? . . . . . Yes ○ No ○

Woman

21. Are you pregnant? . . . . . Yes ○ No ○
22. Do you have any problem associated with your menstrual period? . . . . . Yes ○ No ○
23. Are you nursing? . . . . . Yes ○ No ○
24. Are you taking birth control pills? . . . . . Yes ○ No ○

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date Signature of Patient

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