BOHNING ENDODONTICS
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MEDICAL HISTORY

PLEASE PRINT

IN THE FOLLOWING QUESTIONS, ANSWER YES OR NO, WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Are you now under the care of a physician ..... YES ☐ NO ☐

If so, what is the condition being treated _____

The name and address of my physician is _____

_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD:

Anemia ..... YES ☐ NO ☐
Asthma ..... YES ☐ NO ☐
Arthritis ..... YES ☐ NO ☐
Diabetes ..... YES ☐ NO ☐
Epilepsy ..... YES ☐ NO ☐
Fainting Spells ..... YES ☐ NO ☐
Glaucoma ..... YES ☐ NO ☐
Hepatitis: A Type ..... YES ☐ NO ☐
B Type ..... YES ☐ NO ☐
C Type ..... YES ☐ NO ☐
Immune Deficiency or Lupus ..... YES ☐ NO ☐
Inflammatory Rheumatism ..... YES ☐ NO ☐
Kidney Trouble ..... YES ☐ NO ☐
Liver Disease ..... YES ☐ NO ☐
Knee Replacement ..... YES ☐ NO ☐
Hip Replacement ..... YES ☐ NO ☐
Joint Replacement ..... YES ☐ NO ☐
Rheumatic Fever ..... YES ☐ NO ☐
Sinus Condition ..... YES ☐ NO ☐
Stomach Ulcers ..... YES ☐ NO ☐
Thyroid ..... YES ☐ NO ☐
Venereal Disease ..... YES ☐ NO ☐

Malignancies (Cancer) ..... YES ☐ NO ☐
Radiation Therapy ..... YES ☐ NO ☐
Abnormal Heart Condition:
Heart Surgery ..... YES ☐ NO ☐
Mitral Valve Prolapse ..... YES ☐ NO ☐
Heart Valve Replacement ..... YES ☐ NO ☐
Chest Pain ..... YES ☐ NO ☐
Heart Murmur ..... YES ☐ NO ☐
Heart Attack ..... YES ☐ NO ☐
Coronary Insufficiency ..... YES ☐ NO ☐
Pacemaker ..... YES ☐ NO ☐
Stroke ..... YES ☐ NO ☐
Angina ..... YES ☐ NO ☐
Blood Pressure:
High ___ Low ___ Normal ___
Abnormal Bleeding from:
a Cut ___ an Extraction ___
Hemophilia ..... YES ☐ NO ☐
Are you taking Blood Thinners ..... YES ☐ NO ☐
Women: Are you pregnant ..... YES ☐ NO ☐
Are you taking Birth Control Pills YES ☐ NO ☐
Are you Breast Feeding ..... YES ☐ NO ☐

Other: _____

Have you ever tested positive for HIV/AIDS ..... YES ☐ NO ☐
Have you ever required a blood transfusion ..... YES ☐ NO ☐
If so, explain the circumstances _____

_____

Have you ever had any serious trouble associated with any previous dental treatment ..... YES ☐ NO ☐
If so, explain the circumstances _____

_____

Do you have any disease, condition, or problem not listed above that you think I should know about ..... YES ☐ NO ☐

Are you taking any of the following:

Antibiotics or sulfa drugs ..... YES ☐ NO ☐
Anticoagulants (blood thinners) ..... YES ☐ NO ☐
Medicine for high blood pressure ..... YES ☐ NO ☐
Cortisone (steroids) ..... YES ☐ NO ☐
Tranquilizers ..... YES ☐ NO ☐
Aspirin ..... YES ☐ NO ☐
Insulin, tolbutamide (orinase) or similar drug. YES ☐ NO ☐
Digitalis or drugs for heart trouble ..... YES ☐ NO ☐
Nitroglycerin ..... YES ☐ NO ☐

Are you allergic or have you reacted adversely to:

Local anesthetics ..... YES ☐ NO ☐
Penicillin ..... YES ☐ NO ☐
Other antibiotics ..... YES ☐ NO ☐
Barbiturates, sedatives, or sleeping pills .. YES ☐ NO ☐
Aspirin ..... YES ☐ NO ☐
Other _____

_____

Have you ever had an addiction or problem with alcohol or other drugs ..... YES ☐ NO ☐

Names of medications: _____

_____

The above information that I have provided is true and correct to the best of my knowledge.

Thank You!

X _____

Signature of Patient or Legally Responsible Person

HEALTH HISTORY/CONSENT UPDATE:

Update ____/____/____ To be seen by Dr. _____ Initials _____

Remarks _____ Witness _____

Update ____/____/____ To be seen by Dr. _____ Initials _____

Remarks _____ Witness _____