

# HANOVER ENDODONTICS CONFIDENTIAL PATIENT INFORMATION

## PATIENT MEDICAL HISTORY

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?*

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

Aspirin	<input type="checkbox"/> YES <input type="checkbox"/> NO	Local anesthesia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Penicillin	<input type="checkbox"/> YES <input type="checkbox"/> NO
Codeine	<input type="checkbox"/> YES <input type="checkbox"/> NO	Latex	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other antibiotics	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

**1<sup>st</sup> UPDATE Any changes?** \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Patient/guardian signature

\_\_\_\_\_  
Reviewed by doctor

\_\_\_\_\_  
Date