MARLBOROUGH Endodontics

PATIENT REGISTRATION AND HISTORY

DENTAL HISTORY

Patient Name: ____

Reason for Visit:____

General Dentist: ____

Dentist Address: ____

Dentist City/State: ____

Dentist Phone: (_________) ____________________________________

MEDICAL HISTORY

Physician's Name: ____ Date of last visit: _____________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ______ Yes ______ No

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐Yes	☐No	Glaucoma	☐Yes	☐No	Shortness of breath	☐Yes	☐No
Anemia	☐Yes	☐No	Headaches	☐Yes	☐No	Sinus trouble	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Heart murmur	☐Yes	☐No	Skin rash	☐Yes	☐No
Artificial heart valves	☐Yes	☐No	Heart problems	☐Yes	☐No	Special diet	☐Yes	☐No
Artificial joints	☐Yes	☐No	Hepatitis Type ___________	☐Yes	☐No	Stroke	☐Yes	☐No
Asthma	☐Yes	☐No	Herpes	☐Yes	☐No	Swollen feet or ankles	☐Yes	☐No
Back problems	☐Yes	☐No	High blood pressure	☐Yes	☐No	Swollen neck glands	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No	Jaundice	☐Yes	☐No	Thyroid problems	☐Yes	☐No
Blood disease	☐Yes	☐No	Jaw pain	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Cancer	☐Yes	☐No	Kidney disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Liver disease	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No	Low blood pressure	☐Yes	☐No	Ulcer	☐Yes	☐No
Circulatory problems	☐Yes	☐No	Mitral valve prolapse	☐Yes	☐No	Venereal disease	☐Yes	☐No
Congenital heart lesions	☐Yes	☐No	Nervous problems	☐Yes	☐No	Weight loss, unexplained	☐Yes	☐No
Cortisone treatments	☐Yes	☐No	Pacemaker	☐Yes	☐No	Major surgery? ______________	☐Yes	☐No
Cough, persistent or bloody	☐Yes	☐No	Psychiatric care	☐Yes	☐No	Hospitalized for? _____________	☐Yes	☐No
Diabetes	☐Yes	☐No	Radiation treatment	☐Yes	☐No	Do you wear contact lenses?	☐Yes	☐No
Emphysema	☐Yes	☐No	Respiratory disease	☐Yes	☐No	Take any non-prescribed drugs?	☐Yes	☐No
Epilepsy	☐Yes	☐No	Scarlet fever	☐Yes	☐No	If yes, what and how often? _____________________		
FOR WOMEN ONLY:								
Pregnant? Due date_________	☐Yes	☐No	Taking birth control pills?	☐Yes	☐No	Are you nursing?	☐Yes	☐No

List any medications you are currently taking and the correlating diagnosis:

Med:_____________________________ Dose:__________ Frequency:__________ For:_____________

Med:_____________________________ Dose:__________ Frequency:__________ For:_____________

Med:_____________________________ Dose:__________ Frequency:__________ For:_____________

Med:_____________________________ Dose:__________ Frequency:__________ For:_____________

Pharmacy name: ___________________________Phone (_____) _____________

Indicate any allergies to the following:

☐Aspirin ☐Iodine ☐Penicillin

☐Barbiturates ☐Latex ☐Sulfa

☐Codeine ☐Local anesthetic ☐Other _______

I attest that the dental and medical information above is true and accurate. I accept full responsibility for any information not shared with the doctor.

Patient (or Guardian) Signature:____ **Date:** _______/______/_______