Steve Osmond, DDS, MSD
Practice Limited to Endodontics

Medford Endodontics
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HEALTH HISTORY

Name _____ **Birthdate** _____

Preferred pharmacy and location _____

My Medical Physician is Dr. _____ Phone No. _____

Are you nervous about having dental treatment? ☐ Yes ☐ No

Have you been under the care of a medical doctor in the last 2 years other than normal routine visits? ☐ Yes ☐ No

Have you been a patient in a hospital in the last 2 years? If yes then reason _____ ☐ Yes ☐ No

Have you ever taken medication for osteoporosis or for bone treatment (Fosamax, Zometa, Boniva, Aredia, Actonel, Skelid, Bonefos, Ostac, Didronel, or any other bisphosphonate)? ☐ Yes ☐ No

Has your physician said you need antibiotics or pre-medication 1 hour before dental treatment? (Artificial Joint) ☐ Yes ☐ No

Have you **ever** had any of the following:

High blood pressure	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Respiratory problems	☐ Yes ☐ No	Nervous disorder	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Blood disorder/Anemia	☐ Yes ☐ No
Arrhythmias	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Abnormal bleeding	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Blood transfusion	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Liver disorder	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	AIDS/HIV-positive	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Drug dependency	☐ Yes ☐ No
Heart valve replacement	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	**WOMEN:**	
Stents	☐ Yes ☐ No	Trigeminal Neuralgia	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Due date _____	
Asthma	☐ Yes ☐ No	TMJ problems	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No
Seasonal allergies	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No		

Allergies

☐ Latex ☐ Penicillin or Amoxicillin ☐ Local anesthetics (Novocain) ☐ Codeine or other narcotics

☐ Aspirin ☐ Advil (Ibuprofen) ☐ Other _____

MEDICATIONS *or list attached*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Concerns: _____

_____

To the best of my knowledge, all the above answers are true and correct. I will inform Dr. Osmond of changes in my health and/or medication.

_____ _____

Signature of Patient, Parent or Guardian *Date*