SILBERMAN
ENDODONTICS
7593 Boynton Beach Boulevard, Suite 180
Boynton Beach, Florida 33437
(561) 740-3646

MEDICAL HISTORY

Name: _____ , _____ _____
Last First MI

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you in good health?	Yes	No	
Are you under a physician care now?	Yes	No	If yes, please explain:_____
Are you taking any medications, pills or drugs?	Yes	No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain:_____
Have you ever been hospitalized or had surgery?	Yes	No	If yes, please explain:_____
Do you take, or have taken, Phen-Fen or Redux?	Yes	No	If yes, please explain:_____
Are you on a special diet?	Yes	No	If yes, please explain:_____
Do you use Tobacco?	Yes	No	
Do you use Controlled substances?	Yes	No	

If Female: Are you:
- ☐ Pregnant/Trying to get pregnant?
- ☐ Taking oral contraceptives?
- ☐ Nursing?

Do you have heart trouble or cardiovascular disease?	Yes	No
Do you have damaged or artificial heart valves?	Yes	No
Do you have a cardiac pacemaker?	Yes	No
Do you take aspirin routinely?	Yes	No
Do you have an artificial hip or other prosthetic device?	Yes	No
Have you ever had any trouble with prolonged bleeding?	Yes	No
Have you ever been treated for tumor or cancer?	Yes	No
If yes, please explain: _____		
Have you been told to take antibiotics before dental treatments?	Yes	No
If yes, please explain: _____		

Do you have, or have you had, any of the following?

- ☐ Mitral Valve Prolapse (MVP)
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Anemia
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Venereal Disease
- ☐ Infectious Disease
- ☐ Ulcers
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy

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☐ Kidney Disease
☐ Migraine
☐ Thyroid Disease
☐ Asthma
☐ Lung Disease
☐ Tuberculosis
☐ Liver Disease
☐ Hepatitis
☐ HIV/AIDS
☐ Mental Disorders
☐ Seizures
☐ Epilepsy
☐ Stroke
☐ Drug Dependency
☐ Alcoholism

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Erythromycin ☐ Clindamycin ☐ Tylenol ☐ Ibuprofen
☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other:
Please explain: _____

Do you have any diseases, syndromes, symptoms or other medical problems not mentioned above?
Yes No
If yes, please explain: _____

Name and Address of Physician: _____

_____

Physician's Phone: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I authorize the dentist to release any information, including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payors and /or health practitioners.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____

Relationship: _____

Date: _____