PEAK ENDODONTICS

Cristina Maresca DDS, MS.
Practice Limited to Endodontics

MEDICAL HISTORY

PATIENT NAME_____Birth Date_____

Patients Medical History

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. The following questions must be answered honestly so that our office can provide you with the best possible care. If we determine that questions have not been answered honestly you will be dismissed from our practice.

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa drugs
◯ Other If yes, please explain_____

Have you ever been seriously ill? ☐ Yes ☐ No
Have there been any changes in you general health recently? ☐ Yes ☐ No
Are you currently being treated by a medical Doctor? ☐ Yes ☐ No
If yes, what is the Doctor's Name?_____
Phone Number?_____
Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list_____
Have you ever been hospitalized? ☐ Yes ☐ No
When?_____
Have you ever had a major operation? ☐ Yes ☐ No
Have you had a physical exam in the last year? ☐ Yes ☐ No
Have you ever had to take antibiotics before having dental work? ☐ Yes ☐ No
Do you have artificial joints or heart valves? ☐ Yes ☐ No
Do you have chest pains upon exertion? ☐ Yes ☐ No
Have you ever had x-rays for a tumor, growth or any other condition? ☐ Yes ☐ No
Have you ever been exposed to HIV virus (AIDS)? ☐ Yes ☐ No
Would you consent to a blood test (at our expense) if the Doctor or staff member suffers a needle stick or puncture wound? ☐ Yes ☐ No
Are you currently using any recreational drugs such as cocaine? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No
Have you ever experienced an unusual reaction to dental anesthetic? ☐ Yes ☐ No

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Have you ever been told that any of the following pertain to you?

Mitral Valve Prolapse	☐Yes ☐ No	Heart Murmur	☐Yes ☐ No
High Blood Pressure	☐Yes ☐ No	Diabetes	☐Yes ☐ No
Heart Attack	☐Yes ☐ No	Herpes	☐Yes ☐ No
Hives/Skin Rash	☐Yes ☐ No	Epilepsy	☐Yes ☐ No
Seizures	☐Yes ☐ No	Anemia	☐Yes ☐ No
AIDS	☐Yes ☐ No	Rheumatic Fever	☐Yes ☐ No
Hepatitis	☐Yes ☐ No	Tuberculosis	☐Yes ☐ No
Stroke	☐Yes ☐ No	Jaundice	☐Yes ☐ No
Asthma	☐Yes ☐ No	Hay Fever	☐Yes ☐ No
Venereal Disease	☐Yes ☐ No	Kidney Disease	☐Yes ☐ No
Arthritis	☐Yes ☐ No	Other:_____	

Do you bleed for a long time when you cut yourself?	☐Yes ☐ No
Do you have frequent or severe headaches?	☐Yes ☐ No
Do you have sinus trouble?	☐Yes ☐ No
Do you have painful or swollen joints?	☐Yes ☐ No
Do you have frequent cold sores or canker sores?	☐Yes ☐ No
Do you have complaints about your ears/hearing?	☐Yes ☐ No
Do you have frequent colds?	☐Yes ☐ No
Are you nervous?	☐Yes ☐ No
Have you lost or gained weight in the last few months?	☐Yes ☐ No
Has your appetite changed recently?	☐Yes ☐ No
Are there any foods that you cannot eat?	☐Yes ☐ No

Patient Dental History

Name of Reference Dentist:_____

How long has your tooth been hurting you?_____

Is your tooth pain: ☐ LOCALIZED ☐ DIFFUSE ☐ RADIATING

Is your tooth pain: ☐ SHARP ☐ DULL ☐ THROBBING

My tooth pain is "sensitive/painful" to: ☐ HOT ☐ COLD ☐ BITING ☐ CHEWING ☐ LYING DOWN

RELATED to the TOOTH that you are COMPLAINING about, have you ever experienced, please circle:

(a) SWELLING on the OUTSIDE of your FACE or JAW

(b) SWELLING in the INSIDE of your MOUTH

(c) LYMPH NODE tenderness

(d) A PIMPLE on your GUM near the TOOTH That comes and goes

I have read and understand the above questions, I have answered all of these questions truthfully to the best of my ability and knowledge.

Signature:_____ Date:_____

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