

Please Print

Date _____

ANDY SURESH, D.M.D., M.S.D. **EAST COBB ENDODONTICS, P.C.**

Name _____ Male/ Female Single Married Divorced Widowed
Last First Middle

Address _____ Birth date _____ Age _____ SS# _____

City _____ State _____ Zip _____

Dental Insurance: _____ Policy Holder's Name: _____ Group# _____ ID #: _____

Home Ph. _____ Work Ph. _____ Cell Ph _____

Referring Dentist _____ General Dentist _____ How long with this Dentist _____

MEDICAL HISTORY

Physician _____ Phone # _____

1. Are you under a physician's care now? Yes No Nature of treatment _____

2. Have you ever been hospitalized and/or had surgery? Yes No Reason _____

3. Have you EVER had any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure			Mitral Valve Prolapse			Tuberculosis			Diabetes		
Heart Attack			Heart Valve Replacement			Hepatitis			Thyroid Problems		
Stroke			Artificial Joint			Jaundice			Epilepsy		
Arrhythmias			Asthma			Liver Disorders			Severe Anxiety		
Pacemaker			Seasonal Allergies			Kidney Disease			Blood Transfusion		
Rheumatic Fever			Sinus Problems			Arthritis					
Heart Murmur			Respiratory Problems			AIDS/HIV Positive					
Angina/Chest Pain			Ulcers			Drug Dependency					

4. Other medical concerns: _____

5. Are you currently taking any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO
Antibiotics			Aspirin			Thyroid Medications		
Medicine for High Blood Pressure			Anticoagulants (Blood Thinners)			Steroids		
Digitalis/Other Heart Medications			Tranquilizers (Valium)			Birth Control Pills		
Nitroglycerine			Sedatives			Pain Medications		
Antihistamines			Insulin/Diabetic Medications			Other Medications		

6. If you answered YES to any of the above, list name of the medication and dosage below: _____

7a. Are you sensitive or allergic to any of the following medications? Please check each box.

	YES	NO		YES	NO		YES	NO
Novocaine or Xylocaine			Sulfa			Codeine		
Penicillin			Other Antibiotics			Latex		
Erythromycin			Aspirin			Other Medications		

7b. What type of reaction did you have? _____

8. Have you ever had surgery, x-ray treatment or chemotherapy for a tumor growth?..... Yes No

9. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?..... Yes No

10. Do you have any disease, condition or problem not mentioned above?..... Yes No

11. Female Patients: Are you pregnant? Yes No If Yes, what month? _____ Obstetrician _____

12. Have you ever had endodontic (root canal) treatment before?..... Yes No

13. Have you ever taken bisphosphonate medications? (ex: Fosamax, Actonel, Boniva)..... Yes No

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

Patient's signature _____ Date _____ Reviewed _____

Patient's signature _____ Update _____ Reviewed _____