Matthew O. Cox, D.D.S.

Practice Limited to Endodontics

Name: _____

Birth date: _____

occupation: _____

general dentist: _____

Current Problem

1. Did the current problem involve pain? ☐YES ☐NO

2. How long have you had the pain? _____

3. What makes the pain worse (ex. cold, hot, biting)?

_____

4. Are you currently having sinus problems? ☐YES ☐NO

Medical History

Are you allergic to latex? ☐YES ☐NO

Have you had any of the following:

Prosthetic joint / valve - date: _____	☐YES	☐NO
infective endocarditis	☐YES	☐NO
congenital heart disease	☐YES	☐NO
cardiac transplant	☐YES	☐NO

Have you ever been instructed by a physician or dentist to *ROUTINELY* take antibiotics prior to dental procedures? ☐YES ☐NO

Have you ever taken any of the following medications (commonly used in treating osteoporosis and some cancer therapies):
Alendronate (Fosamax®), Risedronate (Actonel®), Zoledronate (Zometa®), Ibandronate (Boniva®), Pamidronate (Aredia®), Neridronate, or Olpadronate? ☐YES ☐NO

Have you had cancer? ☐YES ☐NO
If yes, what type(s): _____

Has your jaw ever locked open? ☐YES ☐NO

(For women) Are you… pregnant or nursing? ☐YES ☐NO

taking birth control pills? ☐YES ☐NO

Please list all medications you are taking and the reason you are taking it -

medication:	reason:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please indicate the medical conditions you have/had:

☐heart problems	☐diabetes
☐heart attack - date: _____	☐osteoporosis
☐heart surgery - date: _____	☐tuberculosis
☐stroke - date: _____	☐HIV/AIDS
☐pacemaker - date: _____	☐alcoholism
☐hepatitis - type(s): _____	☐drug abuse
☐high blood pressure	☐TMJ
☐respiratory problems	☐emphysema
☐thyroid problems	☐asthma
☐bleeding/clotting disorder	☐sinusitis
☐seizures - most recent: _____	☐migraines
☐inflammatory bowel disease	☐ulcers
☐kidney problems	☐fainting
☐liver problems	☐glaucoma

Check this box if you have/had none of the above: ☐

Please list any other medical condition(s) you have:

_____

_____

_____

_____

Please CIRCLE any of the following to which you are allergic or have had an adverse reaction:

epinephrine	penicillin
ibuprofen	clindamycin
codeine	other: _____
Vicodin®/Lortab®	_____

Signed: Patient or Parent _____ **date:** _____