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MEDICAL HISTORY

The following questions are for our record only and will be considered confidential information.

Do you have or have you had any of the following:

Please circle the correct response and answer all questions.

Yes No..... Latex Allergy?
Yes No..... Rheumatic Fever?
Yes No..... Hypertension (High blood pressure)?
Yes No..... Heart attack, irregular heart rate, damaged heart valves, or angina?
Yes No..... Stroke?
Yes No..... Heart murmur?
Yes No..... Chest pain or shortness of breath on exertion?
Yes No..... Swollen ankles?
Yes No..... Blood disorders such as anemia or hemophilia?
Yes No..... Frequent nosebleeds, increased bruising or bleeding?
Yes No..... Asthma, Tuberculosis or hay fever?
Yes No..... Hives or a skin rash?
Yes No..... Have you ever had a reaction to any drugs?
If yes, which drug? _____
Yes No..... Do you have any allergies?
Yes No..... Are you immunosuppressed (subject to frequent infections)?
Yes No..... Have you been told you have AIDS, ARC or an HIV positive test?
Yes No..... Ulcers, stomach or intestinal problems?
Yes No..... Hepatitis (jaundice) or liver disease?
Yes No..... Diabetes (high blood sugar)?
Yes No..... Tendency to faint, have convulsions, seizures or epilepsy?
Yes No..... Are you taking ANY medications now?
If yes, please list the prescription drugs and non-prescription drugs

_____

_____

Yes No..... Have you taken any steroids in the last six months?
Yes No..... Do you get frequent or severe headaches?
Yes No..... Have you ever had eye, ear, nose or sinus problems?
Yes No..... Do you have difficulty swallowing?

GENERAL

Yes No..... Are you in good health?
Yes No..... Have you ever had Arthritis (painful, swollen joints)?
Yes No..... Have you ever had an artificial joint or a pacemaker placed or replaced?
Yes No..... Cancer, chemotherapy or radiation therapy?
Yes No..... Venereal disease (syphilis, gonorrhea, herpes or other)?
Yes No..... Are you being treated by a physician now?
If yes, for what condition? _____
Yes No..... Been hospitalized, had major surgery or been seriously hurt?
Yes No..... Are you pregnant?
Yes No..... Does your jaw click, pop or hurt when you chew?
Yes No..... Does your physician require you to take an antibiotic before all dental work?

I certify that to the best of my knowledge the above information is complete and accurate. I understand that treatment is no guarantee of success and that factors such as infection, pain, tooth fracture and other complications may affect the outcome of the treatment. I also understand that I am to return to my dentist for a more permanent restoration at the completion of the endodontic treatment.

Patient's signature _____ Date _____