Patient Medical History

Confidential

Are you currently under Physician's care?

☐ Yes ☐ No

If YES please provide Physician's name

First Name Last Name

Physician's phone number

Please enter a valid phone number.

Are you presently taking any drugs prescribed by a physician or dentist?Have you been hospitalized for any surgical operation or serious illnesswithin the last 5 years?

☐ Yes ☐ No

If YES please explain

Are you ALLERGIC to, or have you had any REACTIONS to, the following?

- ☐ Sulfa Drugs
- ☐ Penicillin
- ☐ Codeine
- ☐ Any Antibiotics (If yes, list below)
- ☐ Latex Rubber
- ☐ Local Anesthetics (e.g. novocain)

Other(s) please list

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

- ☐ High Blood Pressure
- ☐ Chest Pains
- ☐ Heart Attack
- ☐ Cardiac Pacemaker
- ☐ Angina
- ☐ Diabetes (type 1, type 2)
- ☐ Mitral Valve Prolapse
- ☐ Arthritis
- ☐ Leukemia
- ☐ Radiation Therapy
- ☐ Migraines
- ☐ Kidney Disease
- ☐ Joint Replacement/Implant
- ☐ AIDS or HIV infection
- ☐ Hepatitis (what kind and what year)
- ☐ Abnormal Bleeding
- ☐ Thyroid
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Fainting/Seizures
- ☐ Diverticulitis
- ☐ Tuberculosis
- ☐ Low Blood Pressure
- ☐ TMJ
- ☐ Liver Disease
- ☐ Epilepsy/Convulsions
- ☐ Cancer (if so what type)
- ☐ Crohn's Disease
- ☐ Asthma
- ☐ Stomach Trouble
- ☐ Ulcers

Other(s) please list

I hereby authorize Endodontic (root canal) dental treatment to be performed on me in this facility. I have been given ample opportunity to ask questions concerning treatment and have recieved adequate information to enable me to make an informed decision as to my care. I also understand that there are some risks associated with Endodontic treatment.