MEDICAL HISTORY

Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	Yes	No
1. Has there been any change in your general health within the past year?	❑	❑
Please specify _____		
2. Are you under the care of a physician for a current problem?	❑	❑
Reason _____		
3. Have you been hospitalized within the past five years?	❑	❑
Reason _____		
4. Are you currently taking any medications or drugs?	❑	❑
Please list _____		
5. Have you received therapy for alcoholism or drug addiction during the past?	❑	❑
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to **LATEX**, anesthetics, antibiotics, or other medications?	❑	❑
Please specify _____		
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?	❑	❑
8. Have you ever required a blood transfusion?	❑	❑
Please explain _____		
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition?	❑	❑
10. Date of last physical exam _____		

11. Do you have or have you had any of the following (please check):

- ❑ High blood pressure
- ❑ Heart murmur of prolapsed valve (MVP)
- ❑ Joint prosthesis (hip, knee, etc.)
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Congenital heart disease
- ❑ Do you have a pacemaker or a Cochlear implant?
- ❑ Cardiovascular disease: heart attack, stroke, by-pass
- ❑ Are you taking any blood thinners?
- ❑ Prosthetic heart valve
- ❑ Blood disorder (e.g., anemia)
- ❑ STD
- ❑ HIV / AIDS
- ❑ Asthma
- ❑ Temporomandibular joint problems (TMJ)
- ❑ Tobacco use
- ❑ Sinus trouble
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Stomach ulcers, colitis
- ❑ Hepatitis, jaundice, liver disease
- ❑ Kidney problems
- ❑ Psychiatric treatment
- ❑ Fainting spells or seizures
- ❑ Epilepsy
- ❑ Cancer
- ❑ Are you currently, or have you taken medicines for Osteoporosis?
- ❑ Delay in healing

12. Do you have any disease, condition, or problem not listed above?	❑	❑
Please specify _____		
13. Are you required to take antibiotic premedication prior to dental treatment?	❑	❑

Women:

14. Are you pregnant?	❑	❑
15. Are you nursing?	❑	❑
16. Do you take birth control pills?	❑	❑
If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.		

All of the above information is true to the best of my knowledge.

PERMISSION FOR ROOT CANAL TREATMENT - I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist unless otherwise advised.

Date _____ Signature of Patient* _____

*All signatures must be by parent or guardian if patient is under the age of 18.