Endodontic Partners

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MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____ PATIENT DOB _____ AGE _____

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

- ☐ Any heart problems
- ☐ Diabetes
- ☐ Epilepsy (Faint Spells, Seizures)
- ☐ Frequent Headaches
- ☐ Growing pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Circulatory problems
- ☐ Nervous Problems
- ☐ Radiation treatments
- ☐ Excessive bleeding
- ☐ A Bad Reaction to "Novocaine"
- ☐ AIDS/HIV
- ☐ Allergies to anesthetics
- ☐ Allergies to medicines or drugs
- ☐ Kidney Disease
- ☐ Ulcer
- ☐ Unexplained Bruises
- ☐ Venereal Disease
- ☐ Anemia
- ☐ Liver Disease
- ☐ Malignancies
- ☐ Hepatitis
- ☐ Measles
- ☐ Mumps
- ☐ Psychiatric Care
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disease (Hives or Skin Rash)
- ☐ Cancer or Tumor
- ☐ Arthritis
- ☐ Swelling of the Ankles
- ☐ Any Pain or Swollen Joints
- ☐ Thyroid Disease
- ☐ Thyroid Fever
- ☐ Tonsillitis
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Stroke

Answer the questions:

YES	NO	
☐	☐	Are you taking any medicine? Specify: _____
☐	☐	Are you being treated by a doctor (physician) now?
☐	☐	Are you pregnant?
☐	☐	Have you taken ACTH or cortisone in the past 12 months?
☐	☐	Gaining or losing weight?
☐	☐	Have you reached Menopause? (change of life)

Blood Pressure: S _____ / D _____ / _____

List any operations or major illnesses during the last 2 years:

_____