"THE ROOT CANAL GUY"

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American Association of Endodontists
Specialist Members

DENTAL TEAM

Medical History

Name_____

	YES	NO
1. Has there been any changes in your health within the past year.....	o	o
Please specify_____		
2. Are you under the care of a physician for a current problem?.....	o	o
Reason_____		
3. Have you been hospitalized within the past five years?.....	o	o
Reason_____		
4. Are you taking any medications or drugs?.....	o	o
Please specify_____		
5. Have you ever had any **ALLERGIC OR ADVERSE REACTIONS** to anesthetics, antibiotics, latex, nickel or other medications?.....	o	o
Please specify_____		
6. Have you received therapy for alcoholism or drug addiction during the past five years?.....	o	o

7. Do you have or have you had any of the following?

o High blood pressure	o Heart murmur(mvp)	o Asthma
o Joint prosthesis (hip,knee,etc)	o Congenital heart disease	o Sinus trouble
o Prosthetic heart valve	o Heart attack,strokes,by-pass	o Cancer
o Blood disorder (e.g. anemia)	o Rheumatic fever	o Diabetes
o Jaundice liver disease	o Epilepsy	o Hepatitis
o Severe Gag Reflex	o Stomach ulcers, colitis	o Thyroid Problems
o Difficulty getting numb	o Fainting spells or seizures	o Venereal Disease
o Dental Anxiety	o Psychiatric treatment	o Kidney Problems
o Temporalmandibular joint problems(TMJ)		

8. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?....	o	o
9. Have you ever required a blood transfusion?.....	o	o
Please explain_____		
10. Have you ever had surgery and/or radiation for tumor, growth, or other conditions?....	o	o
11. Have you ever been tested for HIV infection(AIDS)?.....	o	o
Results of test: Date_____ oPositive oNegative		
12. Date of last physical exam_____		
13. **Do you have any disease, condition, or problem not listed above?**.....	o	o
Please specify_____		
14. Are you **required** to take antibiotics prior to dental treatment?.....	o	o
15. Are you a smoker?.....	o	o

WOMEN:

16. Are you pregnant?.....	o	o
17. Are you nursing?.....	o	o
18. Are you taking birth control pills?.....	o	o

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.

_____ _____

Date Signature of patient*

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

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