MEDICAL HISTORY

PATIENT NAME_______________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No ____________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ____________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ____________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ____________________

Do you use tobacco? ◯ Yes ◯ No ____________________

Do you use controlled substances? ◯ Yes ◯ No ____________________

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ____________________

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

☐ AIDS/HIV Positive	☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Stomach/Intestinal Disease
☐ Alzheimer's Disease	☐ Cancer	☐ Hay Fever	☐ Kidney Problems	☐ Stroke
☐ Anaphylaxis	☐ Chemotherapy	☐ Heart Attack/Failure	☐ Leukemia	☐ Thyroid Disease
☐ Anemia	☐ Chest Pains	☐ Heart Murmur*	☐ Liver Disease	☐ Tuberculosis
☐ Angina	☐ Cold Sores/Fever Blisters	☐ Heart Pace Maker*	☐ Low Blood Pressure	☐ Tumors or Growths
☐ Arthritis/Gout	☐ Congenital Heart Disorder	☐ Heart Trouble/Disease	☐ Lung Disease	☐ Ulcers
☐ Artificial Heart Valve*	☐ Convulsions	☐ Hemophilia	☐ Mitral Valve Prolapse*	☐ Venereal Disease
☐ Artificial Joint*	☐ Diabetes	☐ Hepatitis A	☐ Pain in Jaw Joints	
☐ Asthma	☐ Drug Addiction	☐ Hepatitis B or C	☐ Radiation Treatments	
☐ Blood Disease	☐ Emphysema	☐ Herpes	☐ Renal Dialysis	
☐ Blood Transfusion	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Rheumatic Fever*	
☐ Breathing Problem	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

Comments: ____

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INFORMED CONSENT

I, the undersigned, consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor.

I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. There is a high degree of clinical success, however, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had a root canal treatment may require re-treatment, surgery or extraction.

I understand that following root canal treatment my tooth wil be brittle and must be protected against fracture by placement of a crown (cap) over the tooth. This requires me to return to my general dentist's office and will be done as a separate procedure.

DATE____________________SIGNATURE OF PATIENT OR LEGAL GUARDIAN*______________________________

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