

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? _____

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

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

Comments: _____

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, a permanent restoration is required. This will be done as a separate procedure by my general dentist.

DATE _____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN* _____

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