PREMIER ENDODONTICS

Patient Name: _____ D.O.B. _____

(Although dental personnel primarily treat the area in and out around your mouth, your mouth is a part of your entire body. Health problems that may have, or medications 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? Y __ N __ if yes, please explain: _____
Have you ever been hospitalized or had major operation? Y __ N__ if yes, please explain: _____
Have you ever had serious head or neck injury? Y__ N__ if yes, please explain: _____
Are you taking any medications, Pills, or Drugs? Y__ N__ if yes, please explain: _____
Do you take, or have you taken, Phen-fen, or Redux? Y__ N__
Do you use tobacco? Y__ N__
Do you use controlled substances? Y__ N__
Women: Are you: Pregnant or trying to get pregnant? Y__ N__ Taking oral contraceptives? Y__ N__ Nursing? Y__ N__

Are you **ALLERGIC** to any of the following?
__ Aspirin __ Penicillin __Codeine __ Acrylic __Metal __Latex __Local Anesthetic
Other: _____

Please check if you have any of the following conditions:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Rheumatic Fever
Alzheimer's disease	Diabetes	Hepatitis A	Rheumatism
Anaphylaxis	Drug Addiction	Hepatitis B or C	Scarlet Fever
Anemia	Easily Winded	High Blood Pressure	Sickle Cell Disease
Angina	Emphysema	Hives or Rash	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hypoglycemia	Sinus Trouble
Artificial Heart Value	Excessive Thirsty	Irregular Heartbeat	Spinal Bifida
Artificial Joint	Excessive Bleeding	Kidney Problem	Stomach/Intestinal
Asthma	Fainting Spells/Dizzy	Leukemia	Stroke
Blood Disease	Frequent Cough	Liver Disease	Swelling of Limbs
Blood Transfusion	Frequent Diarrhea	Low Blood Pressure	Thyroid Disease
Breathing Problem	Frequent Headaches	Lung Disease	Tonsillitis
Bruise easily	Genital Herpes	Mitral Valve Prolapse	Tuberculosis
Cancer	Glaucoma	Pain in Jaw Joints	Tumors/Growths
Chemotherapy	Hay Fever	Parathyroid Disease	Ulcers
Chest Pain	Heart Attack	Psychiatric Care	Venereal Disease
Cold Sores/Fever Blister	Heart Murmur	Radiation Treatments	Yellow Jaundice
Congenital Heart Disorder	Heart Pace Maker	Recent Weight Loss	
Convulsions	Heart Trouble/Disease	Renal Dialysis	

Have you ever had any serious illness not listed above? ( ) Y ( ) N Explain: _____

Comments:
_____
_____

(To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.)

Signature: _____ Date: _____