Premier Endodontics Patient Medical History

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

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.)

General Consent for Treatment

I, hereby authorize my doctor's to take x-ray(s), photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs I understand that x-rays are required for accurate diagnosis, I understand that the use of anesthetic agents embodies a certain risk and I acknowledge that I have provided a thorough and honest report of my medical history._____ (Initial)

_____ _____
Signature Date