MICRO ENDODONTICS CONFIDENTIAL PATIENT INFORMATION

Please print and fill out form completely. Thank you.

PATIENT MEDICAL HISTORY

Patients Name: _____ Date: _____

Name of Physician: _____ Phone: _____

Date of Last Visit: _____ Reason for Last Visit: _____

Your current physical health is? ☐ GOOD ☐ FAIR ☐ POOR

Are you taking any medications? ☐ YES ☐ NO

If yes, please list: _____

_____

_____

Have you ever taken Phen-Fen, Redux, or Pondimin? ☐ YES ☐ No If yes, when? _____

Are you currently taking aspirin? ☐ YES ☐ NO Are you taking herbal supplements? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Week #: _____ Are you on birth control? ☐ YES ☐ NO

Have you ever had any of the following diseases or medical problems?

AIDS	☐ YES ☐ NO	Drug Abuse	☐ YES ☐ NO	Knee Replacement	☐ YES ☐ NO
Alcohol Abuse	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	Joint Replacement	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Fainting	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Attack	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO
Bleeding Problems	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO
Blood Transfusion	☐ YES ☐ NO	Heart Surgery	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Breathing Problems	☐ YES ☐ NO	Heart Valve Replacement	☐ YES ☐ NO	Seizures	☐ YES ☐ NO
Cancer/Chemotherapy	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO	Sinus Problems	☐ YES ☐ NO
Colitis	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO	Steroid Therapy	☐ YES ☐ NO
Congenital Heart Defect	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Subacute Bact Endocarditis	☐ YES ☐ NO
Defibrillator	☐ YES ☐ NO	Hip Replacement	☐ YES ☐ NO	Thyroid Treatment	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	HIV	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Dizzy Spells	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Other? Please specify	☐ YES ☐ NO

Do you have any other medical conditions? If so, please list: _____

_____

Have you had any recent hospitalizations? If so, when? _____

_____

Are you allergic to any of the following:

Aspirin	☐ YES ☐ NO	Local anesthesia	☐ YES ☐ NO	Penicillin	☐ YES ☐ NO
Codeine	☐ YES ☐ NO	Latex	☐ YES ☐ NO	Other antibiotics	☐ YES ☐ NO

Please list any other drugs or materials you are allergic to: _____

_____

1st UPDATE Any changes? _____ Date: _____

_____ _____ _____

Patient/guardian signature Reviewed by doctor Date