MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Are you under the care of a physician for a current problem? ☐ Yes ☐ No

   If yes, please list reason: _____

3. Are you taking any medications or drugs? ☐ Yes ☐ No

   If yes, please specify: _____

4. Please CIRCLE any of the following that you currently have or have had:

AIDS/HIV	Heart Attack	Prosthetic Implants
Artificial Heart Valve	Heart Murmur	Radiation Treatment
Asthma	Hepatitis	Rheumatic Fever
Cancer/Malignancy	High Blood Pressure	Stomach Ulcers/Colitis
Cardiovascular Disease	Kidney Disease	Stroke
Congenital Heart Disease	Liver Disease	Temporomandibular Joint Problems (TMJ)
Diabetes	Mitral Valve Prolapse	
Epilepsy or Seizures	Nervous Disorder	Tuberculosis
Fainting	Prolonged Bleeding	Venereal Disease

5. Have you had or do you have any medical problem not listed above? ☐ Yes ☐ No

   If so, please describe: _____

6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to *latex, anesthetics, antibiotics* or other medications? ☐ Yes ☐ No

   If yes, please list: _____

7. Have you experienced an unfavorable reaction from any previous dental treatment? Yes ☐ No ☐

   If yes, please describe: _____

FEMALES:

8. Are you pregnant or nursing? ☐ Yes ☐ No

I, the undersigned, agree that all of the above information is true to best of my knowledge;

Permission for Root Canal Treatment - I, the undersigned, consent to the performing of any dental procedure of the tooth which may be necessary or advisable in the opinion of the doctor. I also understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal treatment has a high degree of success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had a root canal may require re-treatment, surgery or even extraction. I understand that after the root canal treatment, I will need to return to my General Dentist within one month to have the permanent (outside) restoration (filling, crown, inlay, etc.) completed by my General Dentist.

Patient's Signature_____ Date _____

If the patient is a minor, I give permission for examination and endodontic treatment for my minor child named above:

Parent's Signature_____ Date _____