MEDICAL HISTORY

Hudson Endodontics
Practice Limited to Endodontics

DATE_____

PATIENT NAME_____ADDRESS_____CITY_____ZIP_____

HOME PHONE_____CELL or BUS PHONE_____BIRTHDATE_____SEX_____

OCCUPATION_____ SS#_____

NAME OF SPOUSE_____ EMERGENCY CONTACT#_____

REFERRING DENTIST_____REFERRED BY_____

Answer all questions, circle YES or NO, whichever applies and underline where appropriate. Your answers are for our records only and are considered confidential.

1. Do you or have you any of the following diseases or problems?

a. Rheumatic fever, Damaged heart valves or murmur, Artificial heart valves	YES	NO
b. Cardiovascular disease (Heart trouble, Heart attacks, Coronary insufficiency, Coronary occlusion, High blood pressure, Arteriosclerosis, Stroke)	YES	NO
c. Do you have a cardiac pacemaker?	YES	NO
d. Sinus trouble, Asthma or Hay fever (circle)	YES	NO
e. Fainting spells or seizures	YES	NO
f. Diabetes	YES	NO
g. Hepatitis, Jaundice or liver disease	YES	NO
h. Tuberculosis, Venereal disease, Epilepsy	YES	NO
i. Psychiatric problems	YES	NO
j. Cancer, AIDS or other immunosuppressive disorders	YES	NO
k. Temporomandibular joint problems or clicking of jaw joint	YES	NO

2. Do you have any blood disorder such as anemia? YES NO

3. Are you taking any drug or medication? YES NO

If so, what? _____

4. Are you taking any of the following:

a. Antibiotic or sulfa drugs	YES	NO
b. Oral contraceptive or other hormonal therapy	YES	NO
c. Other	YES	NO

5. Are you allergic or have you reacted adversely to:

a. Local anesthetic	YES	NO
b. Penicillin or antibiotics	YES	NO
c. Valium or Versed	YES	NO
d. Sulfa Drugs	YES	NO
e. Aspirin	YES	NO
f. Codeine or other narcotics	YES	NO
g. Latex	YES	NO
h. Other	YES	NO

6. **Do you have any disease, condition, or problem not listed above that you think I should know about?** YES NO

If so, explain_____

7. **Are you pregnant?** YES NO

This is to certify that I have read and understand the above and I authorize release of any information acquired in the course of my examination or treatment.

_____ _____

SIGNATURE OF PATIENT OR PARENT (IF MINOR) **DATE**