Lakeside Endodontics, P.A.

MEDICAL HISTORY

1. GENERAL HEALTH (PLEASE CHECK ONE) EXCELLENT( ) GOOD( ) FAIR( ) POOR( )
2. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? YES( ) NO( )
3. YOUR PHYSICIAN'S NAME AND ADDRESS_____
4. YOUR LAST PHYSICAL EXAMINATION WAS ON:_____
5. ARE YOU CURRENTLY TAKING ANY MEDICATION? YES( ) NO( ) IF YES, FOR WHAT PURPOSE?_____ _____LIST MEDICATIONS: _____
6. DOES YOUR PHYSICIAN REQUIRE YOU TO HAVE ANTIBIOTICS PRIOR TO TREATMENT? YES( ) NO( )
7. HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?: **PLEASE CIRCLE YES OR NO**

HEART DISEASE	YES	NO	STROKE	YES	NO
RHEUMATIC FEVER	YES	NO	GLAUCOMA	YES	NO
ABNORMAL BLOOD PRESSURE	YES	NO	FAINTING SPELLS	YES	NO
ULCERS	YES	NO	PERSISTENT DIARRHEA	YES	NO
TUBERCULOSIS/LUNG DISEASE	YES	NO	THYROID PROBLEMS	YES	NO
DIABETES	YES	NO	RESPIRATORY PROBLEMS	YES	NO
EPILEPSY	YES	NO	KIDNEY PROBLEMS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	CANCER	YES	NO
CONGENITAL HEART DISEASE	YES	NO	ABNORMAL BLEEDING	YES	NO
CARDIAC PACEMAKER	YES	NO	ANEMIA	YES	NO
ARTHRITIS	YES	NO			
			ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?		
AIDS OR HIV INFECTION	YES	NO	LOCAL ANESTHETICS	YES	NO
ANY COMMUNICABLE DISEASE	YES	NO	**PENICILLIN/ANTIBIOTICS**	YES	NO
HEART MURMUR	YES	NO	SULFA DRUGS	YES	NO
JAUNDICE	YES	NO	BARBITURATES/SEDATIVES	YES	NO
ASTHMA OR HAY FEVER	YES	NO	ASPIRIN	YES	NO
SINUS TROUBLE	YES	NO	IODINE	YES	NO
PERSISTENT COUGH	YES	NO	CODEINE /NARCOTICS	YES	NO
HEPATITIS	YES	NO	**LATEX**	YES	NO
ARTIFICIAL JOINTS (hip, knee, etc)	YES	NO	OTHER_____	YES	NO

WOMEN

1. ARE YOU PREGNANT? IF SO, EXPECTED DELIVERY DATE_____ YES NO
2. DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD? YES NO
3. ARE YOU NURSING? YES NO
4. ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

THIS INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE_____ DATE_____

*Reviewed by Doctor prior to treatment.

DOCTOR SIGNATURE_____ DATE_____