Southard Endodontics

Practice Limited to Endodontics

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Medical History (History on Patient)

1. Are you in good health? ❑ Yes ❑ No
2. Have you been seen by a physician in the last five years? ❑ Yes ❑ No
   If so, explain for what conditions: ______________________________
   ____
3. Name of Physician ______________________ Phone ______________
4. Do you have any allergies or sensitivities to penicillin, local anesthetics (novocaine/lidocaine), codeine, demerol, aspirin, or any other medication? ______________ ❑ Yes ❑ No
5. Are you taking drugs or medication now? ❑ Yes ❑ No
   Name ______________________________
6. Do you premedicate with antibiotics for heart problems/joint replacement prior to dental or medical appointments? ❑ Yes ❑ No
   If so, what antibiotic and dosage did you take before today's appointment ______________
   ____
7. Have you ever had an unfavorable reaction following dental treatment? ❑ Yes ❑ No
   If so, please explain: ______________________________
   ____

8. Have you EVER had any of the following? Please check EACH box.

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Heart Valve Problems			Ulcers		
Heart Attack			Heart Valve Replacement			Diabetes		
Arrythmias			Artificial Joint			Epilepsy		
Pacemaker			Bleeding Disorder			Nervous Disorders		
Stroke			Hepatitis			Venereal Disease		
Heart Defect			Jaundice			Herpes		
Rheumatic Fever			Liver Disorder			A.I.D.S. / HIV Positive		
Heart Murmur			Asthma			Glaucoma		
Mitral Valve Prolapse			Respiratory Problems/TB			Chemical Dependency		

If so, please explain below
____
____

9. Have you had any other serious illness? ❑ Yes ❑ No
   Please state: ______________________________
10. Female patients: Are you pregnant? ❑ Yes ❑ No
    Which month ______________________________

Date ______________ Patient/Guardian's Signature: ______________________________

Update ______________ Patient/Guardian's Signature: ______________________________

Update ______________ Patient/Guardian's Signature: ______________________________