Medical History

SOUTHERN MINNESOTA ENDODONTICS

Name:_____ Date:_____

1. Are you now under the care of a physician? Yes___ No___
   a. If so, what is the condition being treated? _____
2. Have you had any serious illness or operation? Yes___ No___
3. Do you have any artificial heart valves, heart defects, hip joints, etc.? Yes___ No___
4. Do you have or have you ever been told you have any of the following diseases or problems?

Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, arteriosclerosis, stroke)	Yes___	No___	High cholesterol	Yes___	No___
			Diabetes, which type?_____	Yes___	No___
Heart Murmur	Yes___	No___	Hepatitis	Yes___	No___
Mitral Valve Prolapse	Yes___	No___	Jaundice or liver disease	Yes___	No___
High Blood Pressure	Yes___	No___	Arthritis	Yes___	No___
Rheumatic heart disease	Yes___	No___	Stomach ulcers	Yes___	No___
Asthma	Yes___	No___	Tuberculosis	Yes___	No___
Fainting spells or seizures	Yes___	No___	HIV Positive	Yes___	No___
Sleep apnea	Yes___	No___	Thyroid trouble	Yes___	No___
Kidney trouble	Yes___	No___	Other:_____		

5. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes___ No___
   a. Have you ever required a blood transfusion? Yes___ No___
   b. If so, when? _____
6. Do you have a blood disorder such as anemia? Yes___ No___
7. Are you taking any of the following drugs or medicines?

Antibiotics or sulfa drugs	Yes___	No___	Tranquilizers or sedatives	Yes___	No___
Anticoagulants (blood thinners)	Yes___	No___	Digitalis or drugs for heart trouble	Yes___	No___
Medicine for high blood pressure	Yes___	No___	Medicine for osteoporosis/cancer	Yes___	No___
Cortisone (steroids)	Yes___	No___	Others:_____	Yes___	No___
Insulin, tolbutamide (Orinase), or similar drug	Yes___	No___	Others:_____	Yes___	No___
Aspirin	Yes___	No___	Others:_____	Yes___	No___

8. Have you ever taken medication for osteoporosis? If so, when did you stop? _____ Yes___ No___
9. Are you allergic or have you reacted adversely to:

Local anesthetics (“Novocaine”)	Yes___	No___	Aspirin	Yes___	No___
Penicillin	Yes___	No___	Latex	Yes___	No___
Other antibiotics	Yes___	No___	Codeine	Yes___	No___
Sulfa drugs	Yes___	No___	Others:_____	Yes___	No___
Barbiturates, sedatives, or sleeping pills	Yes___	No___			

10. Do you have any disease, condition or problem not listed above that you think we should know about? Yes___ No___
11. For women, are you pregnant? Yes___ No___

To the best of my knowledge, I have answered all parts completely and accurately. I will inform my doctor of changes in my health or medications.

X_____ Reviewed by: _____
Signature of Patient or Responsible Party