West GA Endodontics

Medical History

Patient Name _____Referring Dentist _____

Primary Care Physician _____ Are you under a physician's care now? _____

Do you premedicate prior to dental procedures? (Check One) YES_____ NO_____

Please check all that apply to you:

- Heart trouble/surgery/angina
- High blood pressure
- Heart murmur
- Rheumatic fever
- Artificial heart valve
- Artificial joint
- Kidney disease
- Cancer/tumors
- Radiation/chemotherapy
- Lung disease
- Tuberculosis (TB)
- Epilepsy
- Diabetes
- AIDS/HIV
- Hepatitis/liver disease
- Hemophilia/ excessive bleeding
- Drug addiction
- Sexually transmitted disease
- Herpes
- Psychiatric/mental disorder
- Asthma
- Allergies/sinus trouble

Do you take any medications on a daily basis? _____

If so, please list medication(s):

_____

Are you pregnant? _____ How many months? _____ Breastfeeding child? _____

Are you allergic or have you ever had an allergic or unusual reaction to the following medications?

- Dental local anesthetics
- Aspirin
- Tylenol compounds
- Codeine/other narcotics
- Penicillin
- Erythromycin
- Sulfa drugs
- Latex
- Any other antibiotics?

  _____
- Any other medications?

  _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my health, or if my medications change, I will inform the treating doctor.

_____ _____

Patient signature (parent or guardian if minor) Date