

8. Have you ever had, or been told that you had, any of the following diseases or problems?

Yes No		Yes No		Yes No		Yes No	
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Allergic Reaction to:	
Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Frequent Constipation	<input type="checkbox"/> <input type="checkbox"/>	Joint Problems	<input type="checkbox"/> <input type="checkbox"/>	Dental Anesthetic	<input type="checkbox"/> <input type="checkbox"/>
Leaky Heart Valve	<input type="checkbox"/> <input type="checkbox"/>	Spastic Stomach	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Penicillin	<input type="checkbox"/> <input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>	Gastritis	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/>	Erythromycin	<input type="checkbox"/> <input type="checkbox"/>
Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	Ulcers	<input type="checkbox"/> <input type="checkbox"/>	Fainting Spells	<input type="checkbox"/> <input type="checkbox"/>	Tetracycline	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Colitis	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/> <input type="checkbox"/>	Tranquilizers	<input type="checkbox"/> <input type="checkbox"/>
Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Syphilis/Gonorrhea	<input type="checkbox"/> <input type="checkbox"/>	Aspirin	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>	Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Tylenol	<input type="checkbox"/> <input type="checkbox"/>
Stroke	<input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/> <input type="checkbox"/>	Prostate Problem	<input type="checkbox"/> <input type="checkbox"/>	Codeine	<input type="checkbox"/> <input type="checkbox"/>
Lung Disease	<input type="checkbox"/> <input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/>	Headache	<input type="checkbox"/> <input type="checkbox"/>	Antihistamines	<input type="checkbox"/> <input type="checkbox"/>
Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/> <input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/> <input type="checkbox"/>
Persistent Cough	<input type="checkbox"/> <input type="checkbox"/>	Blood Disease	<input type="checkbox"/> <input type="checkbox"/>	Loss of Hearing		Iodine	<input type="checkbox"/> <input type="checkbox"/>
Asthma or Hay Fever	<input type="checkbox"/> <input type="checkbox"/>	Bleed/Bruise Easily	<input type="checkbox"/> <input type="checkbox"/>			Latex	<input type="checkbox"/> <input type="checkbox"/>
Sinus Problems	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/> <input type="checkbox"/>			Other:	
Hives/Skin Rash	<input type="checkbox"/> <input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/>			Other:	

9. Yes No Have you ever taken Fen-Phen for weight Loss?

10. Yes No Have you ever taken or been on bisphosphonates?

11. Yes No Are there any other diseases, conditions or problems not listed above that you think I should know about, or is there any activity your physician says you cannot do? If yes, explain: _____

WOMEN

1. Yes No Are you pregnant or nursing?

2. Yes No Are you taking an oral contraceptive or hormones?

AGREEMENT

I agree to the use of local anesthetic, sedation and analgesia, depending on the judgment of the dentist(s) involved in my case.

I understand that only the endodontic treatment is to be done at this office. The final (outside) restoration (filling, onlay, crown, etc.) will be accomplished by my regular dentist.

I certify that I have read and understand the foregoing. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. If I have any change in my medication or medical status, I will inform the dentist at my next appointment.

Signature of Patient/Parent

Date

Signature of Dentist

Date

ADDITIONAL SPACE
