Chesapeake Endodontic Center
Leaders in Endodontic Microsurgery

Medical History

Name: ______________________________________ **Age**:__________

Height: _________ **Weight:** __________ **Gender**: M F

Medical Physician: _______________________ **Date of last medical exam:**____________

Emergency Contact
Name ________________Relationship:________ Phone number: ______________________

Are you presently under the care of a physician? Yes/No
For what condition: ____
Are you presently taking or have you recently taken any medications? Yes/No
Please list: ____
____
Have you had any serious operation or hospitalization in the past? Yes/No
For what condition: ____
Has there been a change in your health in the last 2 years? Yes/No
Please describe: ____
Do you get short of breath after climbing 1 flight of stairs? Yes/No
Do you use a heart pacemaker? Yes/No
Are you pregnant? Yes/No
Do you take birth control pills? Yes/No
Do you use recreational drugs? Yes/No
Do you smoke cigarettes? Yes/No
Do you drink alcohol? Yes/No
How much per week: ____
Do you require a Premedication prior to any dental treatment? Yes/No

ARE YOU ALLERGIC TO (check all that apply)

____Penicillin	____Aspirin	____Local anesthetic
____Tetracycline	____Tylenol	____Valium
____Other antibiotic	____Codeine	____Nitrous
____ Latex	____Other narcotic	____ Food
____Sulfa Drugs		

Other:____

DO YOU HAVE OR HAVE YOU HAD (check all that apply)

____Heart attack/surgery	____Migraines/headaches	____Cancer
____Angina or chest pain	____TB/tuberculosis	____AIDS or HIV positive
____High blood pressure	____Asthma	____Sexually transmitted disease
____Irregular heart beat	____Emphysema	____Thyroid disease
____Heart murmur	____Diabetes	____Kidney disease
____Rheumatic fever	____Anemia	____Hepatitis
____Congenital heart lesion	____Abnormal bleeding	____Epilepsy
____Artificial heart valve	____Ulcers	____Told not to give blood
____Stroke	____Sinus disease	____Osteoporosis
____Artificial joint	____Glaucoma	**Other**:________________________

Patients Signature__________________________________ **Date**________________

Doctors Signature__________________________________ **Date**________________