CAMBRIAN
ENDODONTICS & MICROSURGERY

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Medical history

1. What is the reason for your visit today? _____

2. Have you been hospitalized or had emergency treatment in a hospital in the past 5 years?
Yes No Why? _____

3. Have you been under a doctor care in the past 2 years? Yes No
Why? _____

4. Have you had problems with prior dental treatment? Yes No

5. Are you currently taking the following medication?

Anticoagulant /Blood thinner	yes	no	Heart Medication	yes	no
Lung or Breathing Medication	yes	no	Nitroglycerine	yes	no
Cortisone/Steroid	yes	no	Blood Pressure Meds	yes	no
Insulin	yes	no	Aspirin	yes	no

6. Are you currently taking any other medication
If yes, Please list:_____
7. Are you allergic? (or have you had a bad reaction) to any medications or food? Yes No
If yes, please list: Medicine_____ Reaction_____
Medicine_____ Reaction_____
Are you allergic to latex? Yes No Other(s)_____

8. Do you have or have you had?

Heart Problem	yes	no	Lung Problem	yes	no	Diabetics	yes	no
Heart Murmur	yes	no	Venereal Disease	yes	no	Ulcers	yes	no
Rheumatic Fever	yes	no	Sinus Problem	yes	no	Arthritis	yes	no
Scarlet Fever	yes	no	Liver Disease	yes	no	Smoke	yes	no
High Blood Pressure	yes	no	Hepatitis/Jaundice	yes	no	Cancer	yes	no
HIV+/ARC/AIDS	yes	no	Alcohol/Drug Problem	yes	no	Radiation	yes	no
Blood Disease/Anemia	yes	no	Psychiatric Treatment	yes	no	Asthma	yes	no
Kidney Disease	yes	no	Epilepsy/Seizures	yes	no	Stroke	yes	no

Have you ever taken any of the group collectively referred to as "fen-phen"? These include combination of lonimin, Adipex, Fastin(brand names of phentermine),Pondimin (fenfluramine) and Redux(dexfenfluramine). Yes No
Fosamax, Actonel or Boniva

9. Have you had placement of an artificial joint, prosthetic heart valve, implant or pacemaker?
Yes No _____

10. Are you subject of prolonged bleeding? Yes No _____

11. Do you have difficulty opening your mouth or popping/clicking or pain in your jaw joints (TMJ)? Yes No
_____

12. Do you wear contact lenses? Yes No _____

13. Women only: Are you or could you be pregnant or nursing? Yes No _____
Are you taking birth control pills? Yes No _____
14. Do you have any other medical condition that we should know about? _____

15. Physician's Name:_____ Phone_____

Patient/Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____