APEX
ENDODONTICS

Name: _____ Date of Birth: _____

Under the regular care of a Physician: ☐ Yes ☐ No Health Condition: _____

Physicians Name: _____ Physicians Phone Number: _____

Do you have or have you had any of the following diseases, medical conditions or procedures? Check if yes:

☐ Heart Attack/Stroke	☐ Thyroid Problems	☐ Cancer/Tumors
☐ Heart Surg/Pacemaker	☐ Kidney Problems	☐ Shingles
☐ Heart Murmur	☐ Liver Problems	☐ Hepatitis
☐ Rhuematic Fever	☐ Respiratory Problems	☐ HIV/AIDS/ARC
☐ Mitral Valve Prolapse	☐ Sinus Problems	☐ Arthiritis/Rheumatism
☐ Artificial Valves	☐ Stomach Problems/Ulcers	☐ Artificial Bones/Joints
☐ Heart Disease	☐ Psychiatric Problems	☐ Emphysema
☐ Congenital Heart Defect	☐ Glaucoma	☐ Fainting/Seizures/Epilepsy
☐ Chest Pains	☐ Alcohol/Drug Abuse	☐ Severe/Frequent Headaches
☐ Scarlet Fever	☐ Tuberculosis	☐ Frequent Neck Pain
☐ Nervousness	☐ TMJ/TMD	☐ Back Problems
☐ Asthma	☐ Xray or Cobalt Treatment	☐ Chemotherapy
☐ Leukemia	☐ Difficulty Breathing	☐ Diabetes/Hypoglycemia
☐ Bleeding Problems	☐ Anemia	☐ High/Low Blood Pressure

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Please list any medications you are taking: _____

_____

Are you allergic to any of the following: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Dental Anesthetics

Please list any other Allergies: _____

FOR WOMEN:

Are you taking Birth Control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No How far along? _____

_____ _____ _____

Signature Date Dr.s Initials