Cape Cod Endodontics, PC

Medical History

Patient's Name: ___________________________ Date of Birth ________________________________

General Health (please check):

- Excellent
- Good
- Fair
- Poor

Are you now under or have you been under the care of a physician within the last year? Yes No

If yes, please explain: ____

____

Name and Address of Physician: ____

____

Are you taking any medications/ supplements now? Yes No

Please list: ____

Have you supplied our office with a current list of your medication? Yes No

Have you had any serious illnesses or injuries? Yes No

If yes, please explain ____

Do you have or have you had any of the following? (Please Circle)

Heart Problems
High Blood Pressure
Heart Murmur
Mitral Valve Prolapse
Pace Maker
Diabetes
Epilepsy
Glaucoma
Rheumatic Fever

Asthma
Ulcers
Sinus Troubles
Hepatitis
Fainting Spells
Allergies
Abnormal Bleeding
Venereal Disease
Lung Disease

Tuberculosis
Kidney Disease
Liver Disease
HIV Virus
Joint/Hip Replacement
Fibromyalgia
Anxiety
Osteopenia/Osteoprosis

Are you Allergic to?

Penicillin Other Antibiotics _________________ Sedatives Aspirin Latex

Codeine Local Anesthetics Other ______________________________

I attest that the above information is true and correct:

Patient Signature ___________________________________ Date ______________________________

Treating Doctor's Signature __________________________ Date ______________________________

I have updated and reviewed my medical history and attest that the above information is true and correct:

Patient Signature ___________________________________ Date ______________________________