

Cedar Rapids Endodontics, PC

Patient First Name MI Last Name Date of Birth Today's Date

Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving today. Thank you for answering the following questions. All information is for our records only and will be kept confidential.

Are you under medical treatment now? If yes, please explain: _____

Please list all current medications:

Please list all drug allergies:

Latex Allergy: Yes or No **Premed Required** (heart/joint): Yes or No If yes, medication: _____

Check the following you have had or currently have:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur/artificial valves | <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Angina/Chest Pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hepatitis, Jaundice, Liver problem | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Delay in Healing |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Aids or HIV |
| <input type="checkbox"/> Emphysema/Lung Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Sinus Condition | <input type="checkbox"/> Eye Disease/Glaucoma | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> History of drug/alcohol abuse | <input type="checkbox"/> Smoker | <input type="checkbox"/> TMJ Pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Problems with Dental Anesthetic | <input type="checkbox"/> Other _____ | | |

Women:

Are you pregnant or think you may be pregnant? Yes or No Are you nursing? Yes or No
 Are you taking an oral contraceptive? Yes or No

* I certify that I have read and I understand the questions above. I will not hold Cedar Rapids Endodontics PC, responsible for errors or omissions that I have made in the completion of this form.

Signature of patient/legal guardian Today's Date Office Staff initials