Cedar Rapids Endodontics PC **Root Canal Specialist** **Red Rock Endodontics**

Patient First Name **MI** **Last Name** **Date of Birth**

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: **Choice of Pharmacy: _____**

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:

__High Blood Pressure	__Low Blood Pressure	__Heart Attack	__Heart Disease
__Heart Murmur/artificial valves	__Mitro Valve Prolapse	__Cardiac Pacemaker	__Angina/Chest Pain
__Stroke	__Rheumatic Fever	__Heart Surgery	__Joint Replacement
__Respiratory Problems	__Epilepsy	__Convulsions	__Fainting
__Hepatitis, Jaundice, Liver problem	__Tuberculosis	__Diabetic	__Delay in Healing
__Cancer	__Leukemia	__Radiation Therapy	__Aids or HIV
__Emphysema/Lung Disease	__Asthma	__Kidney trouble	__Thyroid trouble
__Blood Transfusion	__Abnormal Bleeding	__Anemia	__Hay Fever
__Sinus Condition	__Eye Disease/Glaucoma	__Stomach Problems	__Arthritis
__History of drug/alcohol abuse	__Smoker	__TMJ Pain	__Depression
__Problems with Dental Anesthetic	__ 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**