GREATER MARYLAND ENDODONTICS

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Health Information

Patient Name:_____ Date:_____
Last First MI (Preferred Name)

Date of Last Dental Visit:_____ Reason for today's visit: _____

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV+
- ☐ Ulcers/Colitis
- ☐ Fever Blisters
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ TMJ
- ☐ Hepatitis
- ☐ Tumors
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Venereal Disease
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valves
- ☐ Artificial Bones/Joints
- ☐ Must Pre-medicate
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Excessive Bleeding
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Currently Nursing
- ☐ Currently Pregnant
  Due date:_____
- ☐ Blood Disease
- ☐ Gagging
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Sinus Problems
- ☐ Substance Abuse
- ☐ Bleach Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Aspirin Allergy
- ☐ Other Allergies:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Are you currently taking any prescription/over-the-counter drugs? ☐ Yes ☐ No, If Yes, Please List Below

- Name of Primary Care Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: _____
  _____
  _____

- In the event of an emergency, who should we contact?: _____ Relationship: _____

  Home phone:_____ Work phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date**_____ _____ **Date:** _____
Signature of patient, parent or guardian **Dr's Initials**

MEDICATION	DOSAGE	OFFICE USE