CAPITAL ENDODONTICS

Health Information

Due to the sensitive information on this form, please do not return via email. Please complete in advance and bring it with you at the time of your appointment.

Patient Name _____ Date of Birth _____

Name of Referring Dentist _____

Are you currently taking any drugs and/or medications? ◯Yes ◯No
If yes, please list:

_____

_____

Are you under medical treatment now other than dental treatment? ◯Yes ◯No
If so, please explain _____

Have you ever been hospitalized, had a major operation or serious illnesses? ◯Yes ◯No
If so, please explain _____

Are you allergic to any of the following?

__ Anesthetics
__ Penicillin
__ Codeine
__ Rubbing alcohol
__ Latex
__ Metals
__ Bleach
__ Pain medications
__ Fluoride
__ Iodine
__ Other medications

Please include any items not specified above: _____

Do you presently have, or have you ever had any of the following? (Please check all that apply)

__ Heart attack
__ Heart ailment or disease
__ Heart murmur
__ Pacemaker
__ Stroke
__ Poor blood clotting
__ Blood transfusion
__ Asthma
__ Intestinal disease
__ Liver disease
__ Diabetes
__ Anorexia/bulimia
__ Stomach disease
__ Mental depression
__ Epilepsy
__ Drug abuse/addiction
__ High blood pressure
__ Heart valve implant
__ Mitral valve prolapse
__ Angina (chest pain)
__ Blood disease
__ Hemophilia
__ Respiratory disease
__ Tuberculosis
__ Chemotherapy
__ Hepatitis
__ Artificial joints/prosthesis
__ Tumors or growths
__ Radiation treatments
__ AIDS or HIV
__ Panic attacks
__ Seizures
__ Alcohol abuse/addiction
__ Venereal disease
__ Other _____
__ Other _____

Are you pregnant? ◯Yes ◯No
If so, your expected due date is _____

I certify that the information that I have provided is complete and accurate. I understand that it is my responsibility to notify this dental office of any changes prior to initiating any dental treatment.

Patient Signature _____ Date _____

Health Information Update

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Blood Pressure

Date _____ Reading _____

Date _____ Reading _____

Date _____ Reading _____

Date _____ Reading _____

Date _____ Reading _____

Date _____ Reading _____

Date _____ Reading _____