MEDICAL HISTORY

Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. Has there been any change in your general health within the past year? >>>>>>>>>>> Yes_____ No_____
2. Are you under the care of a physician for a current problem?>>>>>>>>>>>>>>>>>>> Yes_____ No_____
3. Have you been hospitalized within the past 5 years? >>>>>>>>>>>>>>>>>>>>>>>>> Yes _____No_____
4. Have you been out of the United States within the past 30 days? >>>>>>>>>>>>>>>>>Yes_____No_____
5. Are you currently taking any medication or drugs on a regular basis? >>>>>>>>>>>>>> Yes_____No_____
6. Are you allergic to any of the following >>>Aspirin_____Penicillin_____ Codeine_____Acrylic_____
   Metal _____ Latex _____ Local Anesthetics _____ Other please explain _____
7. Have you received therapy for alcoholism or drug addiction during the past 5 years? >>> Yes_____No_____
8. Have you ever had abnormal bleeding with previous extractions, surgery or trauma?>>> Yes_____No_____
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition?>>> Yes_____No_____
10. Have you been tested for HIV Infection (AIDS) >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>Yes_____No_____
    Result of test Date _____ Positive _____ Negative _____
11. Date of last physical exam? _____
12. ***Do you have or have you had any of the following (please check)***

    High Blood Pressure_____ Sinus Trouble _____ Diabetes _____ Thyroid problems _____

    Heart murmur or prolapsed valve (MVP) _____ Congenital heart disease _____ Asthma _____

    Rheumatic fever or rheumatic heart disease _____Prosthetic heart valve _____Tobacco Use _____

    Do you have a pacemaker or a Cochlear implant? _____Are you on Blood Thinners Yes_____No_____

    Stomach Ulcers, Colitis _____ Hepatitis, jaundice, live disease _____ Kidney problems _____

    Cancer _____ Epilepsy _____ Fainting spells or seizures _____ Psychiatric treatment _____ STD _____

    Temporomandibular joint problems?(TMJ) _____ Delay in healing? _____

    - Are you or have you taken medicines for Osteoporosis?>>>>>>>>>>>>>>>>> Yes_____ No_____
    - Are you required to take premeds prior to dental treatment? >>>>>>>>>>>> Yes ____ No_____
    - Are you pregnant? _____ Are you nursing? Yes _____ No_____

    Do you take birth control pills? Yes _____ No _____ If YES, be advised that if you take Antibiotics, analternate method of birth control must be used….

    All the above information is t rue to the best of my knowledge.

    PERMISSION FOR ROOT CANAL TREATMENT – I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office of Dr. Linda Ricks. The permanent (outside), restoration (filling, inlay, crown, etc.) will be completed by my regular dentist or one that is referred to me.

    Date and Signature of Patient _____