LINCOLN ENDODONTICS

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Specialist in Endodontics

MEDICAL HISTORY

Please Circle "Yes" or "No" on Each Item:

Yes	No	Arthritis	Yes	No	Cancer	Yes	No	Dizziness
Yes	No	Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Severe Headaches
Yes	No	Heart Murmur	Yes	No	Diabetes	Yes	No	Epilepsy/Seizures
Yes	No	Mitral Valve Prolapse	Yes	No	Stomach Problems	Yes	No	Thyroid Disease
Yes	No	High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Glaucoma
Yes	No	Chest Pain/Angina	Yes	No	Anemia	Yes	No	Radiation Treatment
Yes	No	Pacemaker	Yes	No	HIV/AIDS	Yes	No	Fainting Tendency
Yes	No	Stroke	Yes	No	Venereal Disease	Yes	No	Hepatitis
Yes	No	Shortness of Breath	Yes	No	Blood Disease	Yes	No	Psychiatric Treatment
Yes	No	Asthma	Yes	No	Liver Disease	Yes	No	Drug Addiction
Yes	No	Hay Fever	Yes	No	Slow Healing	Yes	No	Pain in Jaw Joints
Yes	No	Sinus Trouble	Yes	No	Prolonged Bleeding	Yes	No	Other __________

Are you now or have recently been under a physician's care? (If yes, please explain) __________________
____

Why are you seeking treatment today? ____

Do you need to be premedicated for dental appointments? ________ If yes, why? ____________________

Please list all medications that you are currently taking: ______________________________________
____

Are you allergic or suffer ill effects from (Check if applicable)?

_____Penicillin ______Aspirin _____Sulfa ______Latex _____Sedatives ______Codeine
______Other (List) ____

Women Only: Are you or could you be pregnant? __________ If yes, how many months? __________
Are you nursing? __________

The above medical history is true to the best of my knowledge. Furthermore, I have been given the opportunity to review a copy of this office's Notice of Privacy Practices (HIPPA Policy).

Signature ____ Date ____________________________

Parent (If Minor) _______________________________________ Date ____________________________