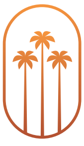

LA JOLLA VILLAGE
Endodontics

CONFIDENTIAL

MEDICAL AND PERSONAL HISTORY

— PLEASE PRINT —

Patient Name: Dr. Mr. Ms. Mrs. ____________________
Birth Date: __________ Social Security No.: __________
Address: ____________________ Apt:________
City:__________ State:__________ Zip__________
Home Phone: ( ) __________ Cell Phone ( ) __________Work Phone: ( ) __________
Email Address: ____________________
Name of Insured: __________ Relationship: __________
Dental Insurance Company: __________ Group/ID No.: __________Employer__________
Emergency Contact Person: __________ Phone: ( ) __________ Relationship: __________

Referring Dentist: ____________________
Medical Doctor: __________ **Phone: ( )** __________ **Last Complete Medical Exam Date:** __________

Circle "Yes" or "No" for each of the following questions. (All answers are confidential.)

Y N Are you in good health today?
Y N Do you smoke?
Y N Have there been any changes in your general health in the last 5 years?
Y N Are you now under the care of a physician or have you been in the last year?
If yes, for what: ____________________
Y N Have you been hospitalized for a serious illness or operation?
If yes, Date: __________ Explanation: ____________________
Y N Are you taking any medications now? List: ____________________
Y N Have you ever been put to sleep for an operation?

Women: Are you pregnant at this time? Yes No Are you taking birth control pills? Yes No

Are you allergic to any medications or have you had an adverse reaction to any of the following? Please check & explain.

- ☐ Local dental anesthetic (Novocaine)
- ☐ Epinephrine
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Clindamycin
- ☐ Barbituates, sedatives or sleeping pills
- ☐ Aspirin
- ☐ Codeine
- ☐ Blood thinning medication: __________
- ☐ Any other medication: __________
- ☐ Latex

Explanation: ____________________

Have you ever hadany of the following conditions? Please check each ☐ that apply.

- ☐ Heart Attack
- ☐ Angina (Chest Pain)
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Arrhythmia
- ☐ Congestive Heart Failure
- ☐ Bypass Surgery
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Aortic Stenosis
- ☐ Prosthetic Heart Valve
- ☐ Other Heart Problems
- ☐ Venereal Disease
- ☐ Heart Pace Make
- ☐ Hip or Joint replacement
- ☐ Breast or other implants
- ☐ Renal Failure
- ☐ Diabetes
- ☐ Liver Disorders
- ☐ Bleeding Disorders
- ☐ Anemia
- ☐ Kidney Disorders
- ☐ Lung Problems
- ☐ Asthma
- ☐ Adrenal Insufficiency
- ☐ Ulcers
- ☐ Cancer
- ☐ Cortisone or ACTH
- ☐ Glaucoma
- ☐ Recent Cough or Cold
- ☐ Radiation Therapy
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Epilepsy or Convulsions
- ☐ Sinus Problems
- ☐ Hepatitis A B C
- ☐ Tuberculosis (TB)
- ☐ Herpes
- ☐ AIDS or HIV Virus
- ☐ Psychological Disorders
- ☐ Gastric Reflux
- ☐ Angioplasty
- ☐ Fen-Phen
- ☐ Other __________

I acknowledge that I have received a copy of this office's Notice of Privacy Practices

Patients Signature: ____________________ Date: __________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patients Signature: ____________________ Date: __________

Recall Signature: __________ Date:________ Recall Signature: __________ Date:________