

WEDGEWOOD
ENDODONTICS

Chris Ettrich DDS, MSD

Medical History

Patient's Name _____ Date of Birth _____

Primary Physician _____ Date of Last Physical Exam _____

In Case of Emergency Please Contact _____ Phone number _____

Please check any of the following that apply to you now or in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Under current medical supervision | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Respiratory/Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension/Circulation | <input type="checkbox"/> Swelling | <input type="checkbox"/> Heart Murmur/Defect |
| <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Recent Weight Gain | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia/Bleeding | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Heart Attack/Stroke |
| <input type="checkbox"/> Diabetes/Kidney | <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Epilepsy/Fainting | <input type="checkbox"/> Prosthetic Implant |
| <input type="checkbox"/> Thyroid/Hormonal | <input type="checkbox"/> Glaucoma/Visual | <input type="checkbox"/> Any Transplant |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Mental/Neural | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Smoking/Tobacco Use | <input type="checkbox"/> Tumor/Neoplasms | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Ulcers/Digestive |
| | <input type="checkbox"/> Infectious Diseases | |

Other illness not listed above: _____

Have you ever had an allergic reaction to or become ill from the following:

- | | | | |
|--------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Nitrous | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Bleach | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Valium | <input type="checkbox"/> Iodine | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Codeine | | <input type="checkbox"/> Food | |

Females, are you: Pregnant? No Yes, wks _____ Taking Birth Control Pills

Please list current medications:

- | | | |
|---|---|--|
| <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Bone Related |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Hormone | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Thyroid | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cortisone/Steroids | <input type="checkbox"/> Ulcer | <input type="checkbox"/> _____ |

Signature of Patient/Guardian

Date