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:

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

Other illness not listed above: _____

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

- ☐ Penicillin
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Tylenol
- ☐ Codeine
- ☐ Narcotics
- ☐ Local Anesthetics
- ☐ Latex
- ☐ Valium
- ☐ Tranquilizers
- ☐ Nitrous
- ☐ Bleach
- ☐ Iodine
- ☐ Food
- ☐ Seafood
- ☐ _____
- ☐ _____
- ☐ _____

Females, are you: Pregnant? ☐ No ☐ Yes, wks_____ ☐ Taking Birth Control Pills

Please list current medications:

- ☐ Antibiotic
- ☐ Pain
- ☐ Heart
- ☐ Aspirin
- ☐ Cortisone/Steroids
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Hormone
- ☐ Thyroid
- ☐ Ulcer
- ☐ Bone Related
- ☐ Antidepressants
- ☐ _____
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient/Guardian Date

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