ARIZONA MICROSCOPIC ENDODONTICS

Andrew J. Krygier, D.M.D.
R. Kristopher Watts, D.M.D.

American Association of Endodontists
Specialist Members

Medical History

Name_____

Please complete the following questions which may help 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.

	YES	NO
1. Have there been any changes in your health within the past year..... Please specify_____	☐	☐
2. Are you under the care of a physician for a current problem?..... Reason_____	☐	☐
3. Have you been hospitalized within the past five years?..... Reason_____	☐	☐
4. Are you taking any medications or drugs?..... Please specify_____	☐	☐
5. Have you ever had any **ALLERGIC OR ADVERSE REACTIONS** to anesthetics, antibiotics, latex, nickel or other medications?..... Please specify_____	☐	☐
6. Have you received therapy for alcoholism or drug addiction during the past five years?.....	☐	☐

7. Do you have or have you had any of the following?

☐ High blood pressure	☐ Heart murmur(mvp)	☐ Asthma
☐ Joint prosthesis (hip,knee,etc)	☐ Congenital heart disease	☐ Sinus trouble
☐ Prosthetic heart valve	☐ Heart attack,strokes,by-pass	☐ Cancer
☐ Blood disorder (e.g. anemia)	☐ Rheumatic fever	☐ Diabetes
☐ Thyroid problems	☐ Epilepsy	☐ Hepatitis
☐ Jaundice liver disease	☐ Stomach ulcers, colitis	☐ Severe Gag reflex
☐ Fainting spells or seizures	☐ Kidney problems	☐ Dental Anxiety
☐ Venereal disease	☐ Psychiatric treatment	
☐ Temporalmandibular joint problems(TMJ)	☐ Difficulty getting numb	

8. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?....	☐	☐
9. Have you ever required a blood transfusion?..... Please explain_____	☐	☐
10. Have you ever had surgery and/or radiation for tumor, growth, or other conditions?....	☐	☐
11. Have you ever been tested for HIV infection(AIDS)?..... Results of test: Date_____ ☐Positive ☐Negative	☐	☐
12. Date of last physical exam_____		
13. Do you have any disease, condition, or problem not listed above?..... Please specify_____	☐	☐
14. Are you **required** to take antibiotics prior to dental treatment?.....	☐	☐
15. Have you ever had a root canal before?..... Was it a positive or negative experience?_____	☐	☐
16. Are you a smoker?.....	☐	☐
17. Have you ever taken Fen-Phen(weight loss)?.....	☐	☐
WOMEN:		
17. Are you pregnant?.....	☐	☐
18. Are you nursing?.....	☐	☐
19. Are you taking birth control pills?..... If yes, be advised that if you take antibiotics, an alternate method of birth control must be used.	☐	☐

All of the above information is true to the best of my knowledge.

_____ _____
Date Signature of patient*

*All signatures must be by a parent or guardian if patient is under the age of 18.

8952 E. Desert Cove Dr., Suite D101 • Scottsdale, AZ 85260 • (480) 661-8333