

Medical History

How would you describe your health? Circle one: **Excellent Good Fair Poor** Last physical exam? ___/___/___

Are you currently being treated for any illness or medical condition? **Y N**

If yes, please explain: _____

Physician's Name: _____ Phone number: _____

Are you currently taking any medications, drugs, herbs? **Y N**

If yes, please list: _____

Have you ever had any surgery? **Y N** Please list: _____

If you had surgery, did you have prolonged bleeding after surgery? **Y N**

Any hip or other joint replacement surgery? **Y N**

Have you ever had any reaction to anesthetic? **Y N** Please explain: _____

Do you have a prosthetic heart valve? **Y N**

Do you have a pacemaker? **Y N**

Do you smoke tobacco? **Y N** If yes, #packs/day: _____

Do you have any drug allergies? **Y N** Please list: _____

Are you allergic to Latex? **Y N**

If you are female, are you pregnant? **Y N** Are you nursing? **Y N**

Please circle any present or past illness listed below:

Alcoholism	Coronary Heart Disease	Heart Murmur	Migraine
Anemia	Depression	Hemophilia	Rheumatic Fever
Angina (Stable / Unstable)	Diabetes (Type: _____)	Hepatitis (Type: _____)	Seasonal Allergies/ Hay Fever
Asthma	Drug Dependency	HIV+	Scarlet Fever
Blood Pressure (High / Low)	Emphysema	Immunodeficiency	Sinusitis
Cancer (Type: _____)	Epilepsy / Seizures	Infectious Disease	Sleep Apnea
Chronic Bronchitis	Head / Neck Injury	Kidney Disease	Ulcers

**Arlington
Alexandria
Endodontics**

Root Canal Specialists
Fernando J Meza DMD | H Vivian Lee DDS | Loken M Patel DMD
Tel: **703.370.1327** Fax: **703.370.1907**
Alexandria Office Arlington Office
4660 Kenmore Ave. #700 1635 N George Mason Drive #410
Alexandria, VA 22304 Arlington, VA 22205

Congestive Heart Failure	Heart Attack (When: _____)	Liver Disease	Thyroid Disease
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Is there anything else we should know about your health? **Y N**

If yes, please explain: _____

Patient/Guardian Signature: _____

Date ____/____/____

Print Name: _____