NAME (in full)

Mr Mrs Miss Ms Dr

ADDRESS

PHONE (mobile) (work) (home)

DATE OF BIRTH MEDICAL/DENTAL FUND

WHO REFERRED YOU HERE FOR ENDODONTIC CARE?

	Yes	No
Have you ever had a longstanding illness? (eg asthma, diabetes, epilepsy etc)		
Are you taking any medication? Please list		
Do you have any allergies? Please list		
Have you ever been treated for osteoporosis?		
Have you ever been treated for cancer?		
Have you ever had a heart condition?		
Have you ever had rheumatic fever?		
Have you ever had prolonged bleeding?		
Have you ever had blood pressure problems ? (high or low)		
Have you ever had hepatitis/HIV/tuberculosis?		
Is there a possibility you are pregnant?		
Do you usually have injections for dental treatment?		
Do you have any problems with local anaesthetic?		

Is there any other medical matter you wish to discuss with the endodontist?

Signature / /