woodside endodontics

Dr. Gregory K. An, DDS, MPH
Dr. Duane B. Gustafson, DMD

MEDICAL HISTORY

Are you currently taking any prescription / over-the-counter drugs? YES ☐ NO ☐
PLEASE LIST ON LINE BELOW

_____

For Women: Are you taking birth control pills? YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐

If so, what week #: _____

Are you nursing? YES ☐ NO ☐

Have you ever had any of the following diseases or medical problems? Please select all that apply.

☐ **Abnormal Bleeding**	☐ **Emphysema**	☐ **High Blood Pressure**	☐ **Sickle Cell Disease**
☐ **Alcohol/Drug Abuse**	☐ **Epilepsy**	☐ **HIV+/AIDS**	☐ **Sinus Problems**
☐ **Anemia**	☐ **Fainting Spells**	☐ **Kidney Problems**	☐ **Stroke**
☐ **Arthritis**	☐ **Frequent Headaches**	☐ **Liver Disease**	☐ **Thyroid Problem**
☐ **Artificial Bones/Joints/Valves**	☐ **Glaucoma**	☐ **Low Blood Pressure**	☐ **Tobacco Habit**
☐ **Asthma**	☐ **Hay Fever**	☐ **Mitral Valve Prolapse**	☐ **Trauma/Injury**
☐ **Blood Tranfusion**	☐ **Heart Attack**	☐ **Pacemaker**	☐ **Tuberculosis (TB)**
☐ **Cancer/Chemotherapy**	☐ **Heart Murmur**	☐ **Psychiatric Problems**	☐ **Ulcers**
☐ **Colitis**	☐ **Heart Surgery**	☐ **Radiation Treatment**	☐ **Venereal Disease**
☐ **Congenital Heart Defect**	☐ **Hemophilia**	☐ **Rheumatic/Scarlet Fever**	☐ **Hospitalized**
☐ **Diabetes**	☐ **Hepatitis**	☐ **Seizures**	Explain: _____
☐ **Difficulty Breathing**	☐ **Herpes/Fever Blisters**	☐ **Shingles**	_____
			_____

Have you experienced any serious conditions / problems not listed above? **YES** ☐ **NO** ☐
If "Yes" please explain: _____

_____

Are you allergic to any of the following? Please select all that apply.

☐ **Aspirin**	☐ **Clindamycin**	☐ **Erythromycin**	☐ **Penicillin**
☐ **Codeine**	☐ **Dental Anesthetics**	☐ **Latex**	☐ **Tetracycline**

Please list any other drugs or items you are allergic to:

_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of this staff responsible for any errors or omissions that I may have made in completion of this form. I understand that I am responsible for payment of services rendered and responsible for paying any co-payments and deductibles that my insurance does NOT cover.

Date: _____ **Signature:** _____

Reviewed by Dr. _____