Waynesboro Endodontics *Practice Limited to Endodontics* William A. Adams, D.D.S
Yaakov R. Barak, D.D.S

Name_____ Date of Birth_____ Marital Status_____ Social Security No._____
First MI Last

Home Address_____ City_____ State_____ Zip_____

Home ph#_____ Alt. ph#_____ Employer_____

Dentist_____ Family Physician_____

Dental Insurance_____ Primary Holder_____

ID No. _____ Primary Holder's Date of Birth_____ Relationship to Primary Holder_____
(*or Primary Holder's Social Security No*)
Person Responsible for payment_____ Relationship_____

How will payment be made today? □ Cash □ Check □ Credit Card *KEEP CREDIT CARD ON FILE? ___YES or ___ NO*

Medical History

(Please circle yes or no)

Are you in good health? .....YES NO
How long ago was your last physical exam? _____
Any changes in health since last year? .....YES NO
Have you had major or minor surgery in the past 5 years? .....YES NO
Are you being treated by a physician? .....YES NO
If so, for what condition? _____
Are you now taking any drug or medication? .....YES NO
If so, what medication? _____
Have you ever had an injury to the face, head, mouth, or teeth? .....YES NO
Please explain_____

Have you ever had any of the following? (*please circle yes or no)*

High blood pressure……...	YES	NO	Syphilis/Gonorrhea……	YES	NO	Epilepsy.....	YES	NO
Low blood pressure……...	YES	NO	Thyroid disease……...	YES	NO	Sexually transmitted disease…….. .	YES	NO
Rheumatic fever…….	YES	NO	Psychiatric treatment or mental disorders…….	YES	NO	Herpes……..	YES	NO
Heart murmur……	YES	NO	Diabetes…….	YES	NO	Cold Sores……	YES	NO
Heart condition….....	YES	NO	AIDS/HIV positive…….....	YES	NO	Hay fever……..	YES	NO
Artificial valve…….	YES	NO	Cancer……	YES	NO	Arthritis…….....	YES	NO
Blood transfusion……...	YES	NO	Chemotherapy……	YES	NO	Asthma…….....	YES	NO
Heart pacemaker……	YES	NO	Lung disease……	YES	NO	Glaucoma……...	YES	NO
Artificial joint……	YES	NO	Anemia……	YES	NO	Tuberculosis……...	YES	NO
Kidney disease……	YES	NO	Abnormal bleeding……	YES	NO	Steroid or hormonal therapy….	YES	NO
Hepatitis or jaundice……...	YES	NO	Alcoholism……	YES	NO	Stomach or intestinal disorders……	YES	NO
Allergies…….	YES	NO	Drug addiction…….....	YES	NO	Fibromyalgia…….	YES	NO
Sinus trouble……..	YES	NO	Nervous disorders…… .	YES	NO			
Stroke……	YES	NO						

Have you ever had an allergic or unusual reaction to any of the following? (*Please circle Yes or No)*

Dental local anesthetics……...	YES	NO	Penicillin…….	YES	NO
Aspirin or Tylenol compounds……...	YES	NO	Erythromycin or other antibiotics……...	YES	NO
Codeine or other narcotics……...	YES	NO	Any other drug or medication…….	YES	NO
Barbituates or tranquilizers…….	YES	NO	Latex……	YES	NO

Is there anything that the dentist should know regarding your medical history that has not been mentioned?.....YES NO
Please explain_____

Women
Are you pregnant?.....YES NO If yes, how many months?_____
Do you anticipate becoming pregnant?.....YES NO
Are you taking birth control pills?.....YES NO
If you have an infant, are you breastfeeding?.....YES NO

To the best of my knowledge all of the proceeding answers are true and correct. If I ever have any change in my health or in my medication I will inform the dentist without fail.

SIGNED:_____ DATE:_____
(parent or guardian, if minor)

MEDICAL HISTORY UPDATE
Addition or change

Date_____ Signature_____

Reviewed by Doctor_____