RGV endodontics LLP

Endodontists

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Medical History Update

Patient name: _____ **Date of birth** _____

Phone _____ Email _____

AN X-RAY(S) IS NECESSARY TODAY TO ESTABLISH A COMPLETE DIAGNOSIS.

I have reviewed the attached Medical History. My (or patients) health and medications have changed as follows (If no change, **write** "No Change"):

_____

_____

Address or Phone# change:

_____

Dental Insurance: ○ No ○ if Yes, Please provide our office with a copy of insurance card or information

_____

Reviewed by ☐ Dr. Ivan E. Rodriguez ☐ Dr. Victor Luikham ☐ Dr. E. G. Trevino

Medical History: please make a check mark whether you now have or have ever been treated for:

☐ AIDS/HIV Positive	☐ Chest Pain	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Anemia
☐ Anemia	☐ Convulsions	☐ Hay fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/ Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care (emotional disorder)	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or growths
☐ Bruise Easily	☐ Fainting Spells/Dizzy	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcer
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Signature of Patient (or guardian) _____ Date _____