

Please indicate whether you have had or currently have each of the following by circling Yes or No to each item.

Paul F. Showers DDS MS PC

Practice Limited to Endodontics

patient _____

date _____

1117 South Milwaukee Avenue
Suite B5
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847 816 3636

Heart (surgery, disease, or attack)	Yes	No
Chest Pain / Angina	Yes	No
Congenital Heart Disease	Yes	No
Heart Murmur	Yes	No
High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No
Rheumatic Fever	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No

Yellow Jaundice	Yes	No
Neurological Disorders	Yes	No
Epilepsy or Seizures	Yes	No
Psychiatric Psychological Care	Yes	No
Nervous / Anxiety	Yes	No
Herbs / Supplements	Yes	No
Smoke	Yes	No
Alcoholism	Yes	No
Drug Addiction	Yes	No

Arthritis / Rheumatism	Yes	No
Cortisone Medication	Yes	No
Swollen Ankles	Yes	No
Stroke	Yes	No
Diet (special or restricted)	Yes	No
Ulcerative Colitis	Yes	No
Kidney Trouble	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No

Any other disease or conditions?

Emphysema / Lung Disease	Yes	No
Chronic Cough	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Allergies or Hives	Yes	No
Latex Sensitivity	Yes	No

Are you taking any medication? Yes No
If so, please list: _____

Fainting / Dizzy Spells	Yes	No
Sinus Trouble	Yes	No
TMJ / Pain in Jaw Joint	Yes	No
Glaucoma	Yes	No

Are you allergic to any medication? Yes No
If so, please list: _____

Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Tumors	Yes	No
Cancer	Yes	No

When did you last see your medical doctor?
Date _____
Physician's Name _____
Physician's Phone _____

Hepatitis (A, B, or C)	Yes	No
Venereal Disease	Yes	No
Herpes	Yes	No
HIV Positive	Yes	No
AIDS	Yes	No
Blood Transfusion	Yes	No
Anemia	Yes	No
Hemophilia	Yes	No
Sickle Cell / Bleeding Disorder	Yes	No
Bruise Easily	Yes	No
Liver Disease	Yes	No

Women
Currently Pregnant Yes No
Currently Nursing Yes No
Birth Control Pills Yes No
Do you take any of the following:
Fosamax Yes No
Aredia Yes No
Zometa Yes No
Bonafos Yes No

General Dentists Name _____
Patient's Signature _____
Date _____