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KEVIN P. CUNNINGHAM, D.D.S., L.L.C.

Practice Limited to Endodontics

11900 West 87th Street Parkway, Suite 160

Lenexa, Kansas 66215

First Name: ______________________ Last Name: ______________________ MI: _____

Social Security #:_____ -_____ - __________ Birth Date ____/_____/_____ Home #(______) ____________________

Work #(_____) ________________ext _____ Cell #(_____) _____________ E-mail: ______________________

Address ____ Apt. #_______________

City _____________________ State ____ Zip _____________ Referred by ______________________

Employer ______________________ Occupation______________________ Male __ Female __ Married __

TELL US ABOUT YOUR MEDICAL HISTORY

How would you describe your health? Please circle one Excellent Good Fair Poor

When did you have your last physical examination?______________________________________

Are you currently being treated for any illness or medical condition? Yes_____No _____

If yes, please describe____

____

Who is treating you for this condition?____

Have you ever had any kind of surgery? Yes ___ No ___ When did you have it? ______________________

What type of surgery did you have? ____

Have you ever had any trouble with prolonged bleeding after surgery? Yes_____No _____

Do you have a pacemaker or any kind of artificial joint? Yes___ No___ Which? ______________________

Are you taking any medication or drugs at this time? Yes_____No _____

What medications, drugs, or herbs are you taking?

____

Why are you taking these medications? ____

____

Ever had a reaction or complication to local anesthetic or drug (like novocaine or penicillin)? Yes_____No _____

If yes, please explain____

Please **circle Yes or No** to any present or past illness you now have or had in the past:

Alcoholism	Y	N	Diabetes (type____)	Y	N	Herpes	Y	N	Nervous or Anxious	Y	N
Allergies	Y	N	Drug Dependency	Y	N	High Blood Pressure	Y	N	Neurologic Disorder	Y	N
Anemia	Y	N	Emphysema	Y	N	HIV/AIDS	Y	N	Respiratory Disease	Y	N
Artificial Heart Valve	Y	N	Epilepsy	Y	N	Infectious Diseases	Y	N	Rheumatic Fever	Y	N
Artificial Joint	Y	N	Fainting or Dizzyness	Y	N	Kidney Disease	Y	N	Sickle Cell Disease	Y	N
Asthma	Y	N	Glaucoma	Y	N	Latex Sensitive	Y	N	Sinus Trouble	Y	N
Bleeding Disorder	Y	N	Head/Neck Injuries	Y	N	Liver Disease	Y	N	Take Cortisone	Y	N
Bruise Easily	Y	N	Heart Disease	Y	N	Lupus	Y	N	Stroke	Y	N
Cancer	Y	N	Heart Murmur	Y	N	Mental Illness	Y	N	Swollen Ankles	Y	N
Chemo or Radiation	Y	N	Heart Surgery (type____)	Y	N	Migraines	Y	N	Tuberculosis	Y	N
Chest Pain	Y	N	Hepatitis	Y	N	Mitral Valve Prolapse	Y	N	Ulcers	Y	N

Are you allergic to Latex or any other substances or materials? Yes_____No _____

If yes, please explain____

If female, are you pregnant? Yes____ No _____What month?___________ Are you nursing? Yes_____No _____

Is there any other information that should be known about your health? ______________________

____

Signature of Patient (or Parent)______________________________________Date________________