PATIENT HEALTH HISTORY

Patient's Name _____ Physician's Name _____

CIRCLE any of the following which you have had or have at the present:

Heart Failure	Stroke	Pain in Jaw Joints	HIV Positive (AIDS)
Heart Murmur	Shortness of Breath	Thyroid Disease	Hepatitis A (infectious)
Mitral Valve Prolapse	Cough, Emphysema	Kidney Trouble	Hepatitis B (serum)
Artificial Heart Valve	Tuberculosis (TB)	Ulcers	Liver Disease
Artificial Joint	Asthma	Rheumatism	Yellow Jaundice
Heart Disease or Attack	Hay Fever	Cortisone Medication	Blood Transfusion
Angina Pectoris (chest pain)	Sinus Trouble	Glaucoma	Drug Addiction
High Blood Pressure	Allergies or Hives	Anemia	Nervousness(excessive)
Congenital Heart Lesions	Diabetes	Prolonged Bleeding	Psychiatric Treatment
Heart Surgery	Cancer or Tumor	Bruise Easily	Epilepsy or Seizures
Heart Pacemaker	Radiation (X-ray) Therapy	Bleeding Disorder	Fainting or Dizzy Spells
Scarlet Fever	Chemotherapy (Cancer)	Hemophilia	
Rheumatic Fever	Arthritis	Cold Sores/Fever Blisters	**NONE OF THE ABOVE**

1. Do you have any disease, condition, or problem not listed?……YES NO
If yes, please list: _____

2. Are you currently taking any drugs or medications?……...YES NO
If yes, please list below.

MEDICATION(S)	Condition/Reason	MEDICATION(S)	Condition/Reason
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

3. Are you **sensitive** or **allergic to** (i.e. rash, swelling of hands, feet, or eyes) any drug or medication?……..YES NO

____ Penicillin	____ Aspirin	____ Codeine	____ Latex
____ Other Antibiotics	____ Ibuprofen (Motrin/Advil)	____ Epinephrine	____ Local Anesthetics

OTHERS NOT LISTED: _____

4. Have you ever been told that you need to **pre-medicate** before a dental appointment?…….……YES NO

5. Women: Are you PREGNANT? YES NO If yes, what month are you due?_____
Are you currently breast feeding?……..YES NO
Are you taking birth control pills?……..…YES NO

6. Is there any other information about your health we should know?……..YES NO

I, the undersigned, affirm that the information above is accurate.
UPON COMPLETION OF ROOT CANAL TREATMENT, I UNDERSTAND THAT I AM TO RETURN TO MY REGULAR DENTIST FOR THE PERMANENT RESTORATION (FILLING AND/OR CROWN).

Signature: _____ Date: _____ Update:_____Date: _____