



HEALTH HISTORY

Patient Name: _____ Date: _____

1. Are you experiencing pain from your mouth at this time? _____ If so, where? _____
2. Have you noticed any loose teeth? _____
3. Are your teeth sensitive to heat, cold or sweets? _____
4. On a scale of 0-10, how important are your teeth to you? _____
5. Do you consider your general health to be Good? _____ Fair _____ Poor _____
6. When was your last physical exam? _____ Findings? _____
7. Has your health changed within the last year? _____ Explain: _____
8. Are you being treated by your physician at this time? _____ If so, why? _____

Name of Physician: _____ Phone# () _____

9. Are you taking any medications? _____ If so, please list below:

10. Have you ever had, or do you now have, any of the following? (please circle all that apply)

- | | | |
|--------------------------|-----------------------|-------------------|
| AIDS/HIV | EPILEPSY | PACEMAKER |
| ANEMIA | HEART ATTACK | RADIATION THERAPY |
| ARTHRITIS | HEART MURMUR | RHEUMATIC FEVER |
| ARTIFICIAL HEART VALVE | HEPATITUS | SINUS PROBLEMS |
| ARTIFICIAL KNEE/HIP | HERPES I or II | SKIN DISEASE |
| ASTHMA | HIGH BLOOD PRESSURE | STOMACH PROBLEMS |
| BLEEDING PROBLEMS | KIDNEY DISEASE | STROKE |
| BLOOD DISEASE | LIVER PROBLEMS | THYROID DISEASE |
| CLOTTING PROBLEMS | LUNG PROBLEMS | TUBERCULOSIS |
| COLD SORES | MALIGNANCY/CANCER | ULCERS |
| CONGESTIVE HEART FAILURE | MITRAL VALVE PROLAPSE | VENEREAL DISEASE |
| DIABETES | HEART DISEASE | |

WOMEN: ARE YOU PREGNANT? _____ WHICH MONTH? _____

ORAL CONTRACEPTIVES? _____ HORMONES? _____

11. Have you taken Cortisone/Steroids within the last 2 months? _____
12. Have you taken any blood thinners? _____
13. List any and all drug allergies: _____
14. Have you had any major surgeries within the last year? _____
15. Please describe any current medical treatment, impending operations, or other information that may possibly affect your endodontic care: _____

To the best of my knowledge all of the above answers are true and correct. If I have any changes in my health, or if my medications change I will inform my dentist at my next appointment. I further agree to pay all finance charges, collection fees, attorneys fees, and any other cost that may be incurred due to the collection of any outstanding amount.

Signature of Patient or Guardian _____