ENDODONTIC ASSOCIATES

Dr. James Burquest • Dr. Perri Carnes • Dr. Brock Deal Dr. Tim Hubble • Dr. Anita Hoelscher

HEALTH HISTORY

Patient Name_____ **Date of Birth**_____

Employer_____

General Dentist/Referring Doctor_____

Please indicate if you have ever had the following:

- ❑ Mitral Valve Prolapse
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Other Heart Condition (specify): _____
- ❑ High Blood Pressure
- ❑ Bleeding Problems
- ❑ Stomach Problems
- ❑ Ulcers
- ❑ Kidney Condition
- ❑ Liver Condition
- ❑ Thyroid Condition
- ❑ Asthma
- ❑ Diabetes
- ❑ Sinus Condition
- ❑ Glaucoma
- ❑ Lung Condition
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ Drug or Alcohol Abuse
- ❑ Venereal Disease
- ❑ Tuberculosis
- ❑ Do you wear a heart "pacemaker"?
- ❑ HIV
- ❑ Joint Replacement(s) Date(s)_____
- ❑ Other (specify) _____
- ❑ Are you pregnant? Due date: _____

❑ Have you ever experienced any unusual reaction/allergy to ANY medications *including* local anesthetic; aspirin; Tylenol; codeine; penicillin?
Please list_____

❑ Do you have any other allergies? _____

❑ Have you taken any medications within the past six months?
If yes, please give name(s) of the medication(s) and reasons for taking them:

_____

_____

❑ Have you ever been hospitalized for a serious condition? If yes, please specify:

_____

❑ Are you presently under the care of a physician? Name: _____

_____ _____
Signature Date Witness

_____ _____
Update Date Witness