ENDODONTIC
ASSOCIATES
Root Canal Therapy & Microsurgery

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
- ❑ Joint Replacement(s) Date(s)_____
- ❑ Other (specify) _____
- ❑ Are you pregnant? Due date: _____
- ❑ Asthma
- ❑ Diabetes
- ❑ Sinus Condition
- ❑ Glaucoma
- ❑ Lung Condition
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ Drug or Alcohol Abuse
- ❑ Venereal Disease
- ❑ Tuberculosis
- ❑ Do you wear a heart "pacemaker"?
- ❑ HIV

❑ **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**

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