

HEALTH HISTORY

After the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year? Yes No
If yes, explain: _____
2. Are you now under the care of a physician? Yes No
If so, for what condition? _____
3. Have you had any serious illness or operation? Yes No
 - a. If so, what was the illness or operation? _____
 - b. Any artificial heart valves, hip joints, etc.? _____
4. Do you have or have you ever been told you have any of the following diseases or problems?
 - a. Rheumatic fever or rheumatic heart disease Yes No
 - b. Mitral valve prolapse, heart murmur (please circle one) Yes No
 - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, high blood pressure, arteriosclerosis, stroke) Yes No
 - d. Drug allergies Yes No
Please list: _____
 - e. Fainting spells or seizures Yes No
 - f. Kidney trouble Yes No
 - g. Diabetes Yes No
 - h. Hepatitis, jaundice or liver disease Yes No
 - i. Stomach ulcers Yes No
 - j. Tuberculosis Yes No
 - k. Cancer Yes No
5. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No
 - a. Do you bruise easily? Yes No
 - b. Have you required a blood transfusion, radiation, or x-ray treatment? Yes No
 - c. Do you have any blood disorder such as anemia? Yes No
If so, please explain _____
6. Have you had any serious trouble associated with previous dental treatment? Yes No
If so, please explain _____
7. Do you need to be premedicated with antibiotics before dental treatment? Yes No
8. Are you taking any drug or medicine? Yes No

a. Antibiotics or sulfa drugs	Yes No	f. Tranquilizers or sedatives	Yes No
b. Anticoagulants (blood thinners)	Yes No	g. Insulin or oral hypoglycemics	Yes No
c. Medicine for high blood pressure	Yes No	h. Drugs for heart trouble	Yes No
d. Cortisone (steroids)	Yes No	i. Others _____	
e. Nitroglycerin	Yes No		
9. Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No
If yes, please explain: _____
10. Are you allergic or have you reacted adversely to:

a. Local anesthetics (lidocaine)	Yes No	d. Aspirin	Yes No
b. Penicillin or other antibiotics	Yes No	e. Codeine	Yes No
c. Barbiturates, sedatives, or sleeping pills	Yes No	f. Others _____	
11. Do you have AIDS, ARC or are you HIV positive? Yes No
12. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax or Zometa, within the past twelve years? Yes No

Women

13. Are you presently pregnant or is it possible you may be pregnant? Yes No
14. Are you breast feeding? Yes No
15. Do you take birth control pills? Yes No
If **YES**, be advised that while you take antibiotics, an alternate method of birth control must be used until the beginning of your next menstrual cycle.

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or my medicines, I will inform the doctor at the next appointment.

(X) _____
Signature of Patient, Parent or Guardian Date

I, the undersigned, consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor. I accept full financial responsibility for the treatment performed by the doctors in this office. Full payment is expected at the time of services unless other arrangements have been made.

I also understand that I will need to contact my regular dentist promptly after completion of my root canal treatment for permanent restoration (filling, inlay, crown, etc.) of the tooth treated.

(X) _____	BP	DATE	BP	DATE
Signature of Patient, Parent or Guardian Date				
	PULSE			