Endodontic Associates Patient Health History Form

Last name: _____ First name: _____ Preferred name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred method of contact: _____

Employer: _____ Referred by: _____ General Dentist: _____

Please indicate any medical conditions by marking the boxes below.

- ☐ Under Current Med Tr
- ☐ Pregnant or Trying
- ☐ High Blood Pressure
- ☐ Hypertension/Circulatory
- ☐ Respiratory/Asthma
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Thyroid/Hormonal
- ☐ TMJ Problems
- ☐ Immunocompromised/HIV+
- ☐ Oral Herpes
- ☐ Cancer/Tumor/Neoplasm
- ☐ Radiation/Chemo
- ☐ Blood Disease
- ☐ Anemia/Bleeding Problem
- ☐ Over/Underweight
- ☐ Stroke
- ☐ Migraine/Headaches
- ☐ Epilepsy/Fainting
- ☐ Glaucoma/Visual
- ☐ Mental/Psych/Neural
- ☐ Ulcers/Digestive
- ☐ Alcoholism/Addiction
- ☐ Infectious Diseases
- ☐ Smoking
- ☐ Arthritis
- ☐ Heart Disease/Defect
- ☐ Chest Pain with Exercise
- ☐ Shortness of Breath
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Prosthetic Implant
- ☐ Any Transplant
- ☐ Joint Replacement
- ☐ Other Med Hx Concern

Allergies

- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Aspirin
- ☐ Tylenol/Acetaminophin
- ☐ Ibuprofen
- ☐ Other Anti-inflammatory
- ☐ Codeine
- ☐ Other Narcotics
- ☐ Local Anesthesia
- ☐ Valium/Tranquilizers
- ☐ Other Medications
- ☐ Latex
- ☐ Food
- ☐ Other - Note Below

Medications

- ☐ No Medications
- ☐ Antibiotic
- ☐ Pain Medicine
- ☐ Heart Medicine
- ☐ Aspirin
- ☐ Cortisone/Steroids
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Horomone
- ☐ Thyroid
- ☐ Birth Control Pills
- ☐ Diabetes Medication
- ☐ Ulcer/Digestive
- ☐ Bone Related
- ☐ Antidepressants
- ☐ Other Medications
- ☐ Non-Prescription

Height: _____ Weight: _____ Blood pressure, if known: _____/_____

History of hospitalizations: _____

_____

Please note all medications and dosages: _____

_____

_____

Other: _____

_____

The information above is correct.

Print Name	Signature	Date
_____	_____	_____