ENDODONTIC ASSOCIATES

Health History

Patient Name _____
First Name MI Last Name

Pharmacy Name _____ Pharmacy Phone _____

Have you ever taken any of the group of drugs referred to as "bisphosphonates"? ☐ Yes ☐ No
(Example: Fosamax, Actonel, Aredia, Zometa)

Have you ever been hospitalized or had a serious illness with the past 5 years? ☐ Yes ☐ No

Do you require premedication with antibiotics for any of the following reasons? □ Artificial Joint □ Heart

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?
PLEASE CHECK YES OR NO ON EACH CONDITION.

Y / N		Y / N		Y / N	
☐	☐ AIDS/HIV	☐	☐ Congenital Heart Condition	☐	☐ Psychiatric Care
☐	☐ Alzheimer's Disease	☐	☐ Diabetes (type ___)	☐	☐ Radiation Treatment
☐	☐ Anemia (type___)	☐	☐ Ear (Cochlear) Implant	☐	☐ Respiratory/Breathing
☐	☐ Arthritis/Rheumatism	☐	☐ Emphysema	☐	☐ Rheumatic Fever
☐	☐ Artificial Heart Valve	☐	☐ Epilepsy or Seizures	☐	☐ Sinus Trouble
☐	☐ Artificial Joints	☐	☐ Glaucoma	☐	☐ Steroid Treatment
☐	☐ Asthma	☐	☐ Heart Murmur	☐	☐ Stroke
☐	☐ Back/Neck Problems	☐	☐ Heart Disease/Surgery	☐	☐ TMJ Disorder
☐	☐ Bleeding Abnormality	☐	☐ Hepatitis (type ___)	☐	☐ Tuberculosis
☐	☐ Blood Thinners	☐	☐ High Blood Pressure	☐	☐ Tumor or Growth
☐	☐ Cancer	☐	☐ Kidney Disease	☐	☐ Ulcer
☐	☐ Chemical Dependency	☐	☐ Liver Disease	☐	☐ Venereal Disease
☐	☐ Chemotherapy	☐	☐ Pacemaker	☐	☐ Other_____

FEMALES ONLY:

Are you pregnant? ☐ Yes ☐ No Due Date_____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

List any **MEDICATIONS** you are currently taking and correlating diagnosis:

_____

_____

_____

_____

Check box for **ALLERGIES**:

☐ Aspirin or NSAIDS	☐ Local Anesthetic	☐ Latex
☐ Penicillin	☐ Codeine	☐ Sulfa Drugs
☐ Iodine	☐ Other _____	

I have answered above completely and accurately.

Signature (patient or parent/guardian) _____Date _____