HEALTH HISTORY

Information about your health will be held as confidential by this office and will be released upon your expressed consent. Many general health factors may affect your oral health and influence our treatment. Therefore, it is important for you to complete this form accurately and in its entirety. Thank you.

1. General health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

   Physician's Name ______________________________

2. Please circle any of the following you have or have had:

Artificial Heart Valve	Heart Murmur	Asthma	Fainting
Prosthetic Implants	High Blood Pressure	Diabetes	Nervous Disorder
Mitral Valve Prolapse	Hepatitis	Liver Disease	Prolonged Bleeding
Rheumatic Fever	Tuberculosis	Kidney Disease	Heart Attack
AIDS/HIV	Cancer/Malignancy	Radiation Treatment	Epilepsy or Seizures

	YES	NO
3. Do you have a pacemaker?	☐	☐
4. Have you had, or do you have any medical problem NOT mentioned above? .... (If yes, please describe.)	☐	☐
5. Are you now being treated by a physician?	☐	☐
6. Do you take any drug/medication for your tooth or a medical problem? If yes, please list:	☐	☐
7. Are you allergic to penicillin, codeine or any other drug? .... If yes, please list:	☐	☐
8. Are you allergic to latex?	☐	☐
9. Have you experienced an unfavorable reaction from any previous dental treatment?	☐	☐
10. Have you ever had Root Canal Treatment?	☐	☐
FEMALES		
11. Are you pregnant?	☐	☐

Patient's
Signature ______________________________ Date ____________

If the patient is a minor:
Parent's Signature ______________________________

I give permission for examination and endodontic treatment for my minor child, named above.