HEALTH QUESTIONS

Yes	No	
☐	☐	Do you normally take antibiotics before dental appointments?
☐	☐	Have you been a patient in a hospital in the past 2 years?
☐	☐	Have you been under the care of a physician during the past year?
		Physician Name: ______________________________ Phone: ( ) ________________
☐	☐	Are you currently taking any medications?

Please list (including aspirin or birth control): ____

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☐	☐	Are you subject to prolonged bleeding?
☐	☐	Women: are you nursing or pregnant? How many months? _______
☐	☐	Hip or other joint replacement? When? __________
☐	☐	Do you have TMJ (jaw) problems?

PLEASE CIRCLE ANY ILLNESS YOU HAVE HAD OR HAVE PRESENTLY:

Heart attack	Anemia	Hepatitis
when? ________	Hemophilia	AIDS/HIV+
Heart murmur	Other blood disorders	Tuberculosis
Mitral valve prolapse	Transfusion	IV drug use
Prosthetic heart valve	when? ________	Chemical dependence
Pacemaker	Epilepsy	Psychiatric treatment
Other heart problems	Kidney problems	Thyroid problems
Stroke	Liver damage	Cancer - radiation - &/or chemotherapy
Rheumatic fever	Intestinal problems	Type of Cancer? ________
High blood pressure	Asthma	Hay fever/allergies
Diabetes	Other respiratory disease	

CIRCLE ITEMS TO WHICH YOU HAVE REACTIONS OR ALLERGIES:

penicillin	aspirin	valium	local anesthetic	nickel
clindamycin	ibuprofen	codeine	latex	

LIST OTHERS:____

IS THERE ANY OTHER INFORMATION REGARDING YOUR HEALTH OR PAST EXPERIENCES WITH DENTAL TREATMENT / ROOT CANALS THAT WE SHOULD KNOW?____________________

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I hereby certify that the above information is correct to the best of my knowledge:

______________________ ____

TODAY'S DATE SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Doctor Signature____ Date ______________