EASTERN IOWA
ENDODONTICS

HEALTH HISTORY

PATIENT NAME ____ BIRTH DATE____

Are you under a physician's care now? YES NO If yes, please explain: ____

Physician's Name/Address ____

Do you require **PREMEDICATION** prior to dental treatment? YES NO

If yes, for which of the following? Heart (Infective Endocarditis, Artificial Valve, etc.) Joint Replacement (Knee, Hip or other)

Do you use **CONTROLLED SUBSTANCES**? YES NO

Do you have a **LATEX ALLERGY**? YES NO

Are you **ALLERGIC** to any of the following? NONE

Codeine Local Anesthetics Penicillin Sulfa Other:____

Have you taken or are you currently taking **BISPHOSPHONATE MEDICATIONS** (Ex. Actonel, Boniva, Fosamax, Zometa, etc.)? YES NO

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

_____ AIDS/HIV Positive	_____ Chest Pains	_____ Hypoglycemia	_____ Radiation Treatment
_____ Alzheimer's Disease	_____ Cortisone Medicine	_____ Intestinal Disease	_____ Renal Dialysis
_____ Anaphylaxis	_____ Diabetes	_____ Irregular Heartbeat	_____ Shingles
_____ Anemia	_____ Drug Addiction	_____ Kidney Problems	_____ Sinus Trouble
_____ Angina	_____ Epilepsy/Seizures	_____ Leukemia	_____ Stroke
_____ Arthritis	_____ Excessive Bleeding	_____ Liver Disease	_____ Substance Abuse
_____ Artificial Joint	_____ Fainting/Dizziness	_____ Low Blood Pressure	_____ Swelling of Limbs
_____ Asthma	_____ Frequent Headaches	_____ Lung Disease	_____ Thyroid Disease
_____ Blood Disease	_____ Heart Problems	_____ Neuralgia/Neuritis	_____ Trigeminal Neuralgia
_____ Breathing Problem	_____ Hemophilia	_____ Pacemaker	_____ Tuberculosis [active]
_____ Bruise Easily	_____ Hepatitis A, B or C	_____ Pain in Jaw	_____ Tumors or Growths
_____ Cancer	_____ High Blood Pressure	_____ Parathyroid Disease	_____ Ulcers
_____ Chemotherapy	_____ Hives or Rash	_____ Psychiatric Care	_____ Venereal Disease

Are you currently pregnant: YES NO Are you breastfeeding: YES NO

Have you ever had any serious illness not listed above? YES NO

If yes, please explain: ____

____

PLEASE LIST ALL MEDICATION THAT YOU ARE CURRENTLY TAKING

1)________________________	4)________________________	7)________________________
2)________________________	5)________________________	8)________________________
3)________________________	6)________________________	9) ________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE ______________