PATIENT HEALTH HISTORY

NAME___________________________________ PHYSICIAN'S NAME_____________________

PHYSICIAN'S ADDRESS___________________ PHYSICIAN'S PHONE/FAX________________

Y N CONDITIONS	Y N CONDITIONS	Y N CONDITIONS
☐ ☐ Heart Murmur	☐ ☐ Emphysema	☐ ☐ Stroke
☐ ☐ Rheumatic Fever	☐ ☐ Epilepsy	☐ ☐ Thyroid Problems
☐ ☐ Mitral Valve Prolapse	☐ ☐ Fainting Spells	☐ ☐ Tobacco
☐ ☐ Congenital Heart Defect	☐ ☐ Fever Blisters	☐ ☐ Tuberculosis
☐ ☐ Artificial Heart Valve	☐ ☐ Frequent Headaches	☐ ☐ Ulcers
☐ ☐ Heart Attack	☐ ☐ Glaucoma	☐ ☐ Venereal Disease
☐ ☐ Alcohol Abuse	☐ ☐ HIV AIDS	☐ ☐ Do you premedicate with antibiotics for joint replacements or heart condition?
☐ ☐ Allergies-Seasonal	☐ ☐ Heart Surgery	
☐ ☐ Anemia	☐ ☐ Hemophilia	**Y N Allergies**
☐ ☐ Angina Pectoris	☐ ☐ Hepatitis A	
☐ ☐ Arthritis	☐ ☐ Hepatitis B	☐ ☐ Aspirin
☐ ☐ Asthma	☐ ☐ Hepatitis C	☐ ☐ Codeine
☐ ☐ Blood Transfusion	☐ ☐ High Blood Pressure	☐ ☐ Dental Anesthetics,____________
☐ ☐ Abnormal Bleeding	☐ ☐ Hip Replacement__________(yr)	☐ ☐ NSAIDS,____________________
☐ ☐ Bruise Easily	☐ ☐ Jaw Pain/TMJ Problems	☐ ☐ Latex
☐ ☐ Cancer	☐ ☐ Knee Replacement_________ (yr)	☐ ☐ Penicillin
☐ ☐ Chemotherapy		
☐ ☐ Coumadin Therapy	☐ ☐ Kidney Problems	Other Allergies, Drugs/Medicines
☐ ☐ Radiation Treatment	☐ ☐ Liver Disease	____________________________
☐ ☐ Colitis	☐ ☐ Low Blood Pressure	**Y N If female, please answer the following**
☐ ☐ Diabetes	☐ ☐ Pace Maker	☐ ☐ Are you taking Birth Control Pills
☐ ☐ Difficulty Breathing	☐ ☐ Psychiatric Problems	☐ ☐ Are you pregnant? If yes # weeks_______
☐ ☐ Drug Abuse	☐ ☐ Seizure	☐ ☐ Are you nursing?
	☐ ☐ Sickle Cell Disease	

If yes to any of the above indicate date of diagnosis/treatment ____

If you were referred as a result of oral trauma, provide details including dates?__________________________________

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Have you been hospitalized in last 5 years? ______If so describe circumstance________________________________

Y☐ N ☐ **Currently taking or have you previously taken bisphosphonate medications such as Actonel, Boniva, Fosamax or Zometa within the past 12 years. Are you taking Prolia or Xgeva?**

Medications currently being taken, prescriptions and OTC:

Consent Statement

I, the undersigned, affirm that the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Breeland or any member of the office staff responsible for errors or omissions that I have made in the completion of this form. I consent to any advisable and necessary endodontic therapy to be administered by Dr. Breeland or her supervised staff for diagnostic purposes or dental treatment. I realize that treatment is no guarantee of success and factors such as post-treatment inflammation, infection and tooth fracture may complicate the prognosis, resulting in retreatment, surgery or extraction. I understand that I am to return to my dentist for permanent restoration of the treated tooth.

Patient (Parent/Guardian Signature)____ **Date** _______________________