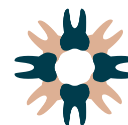

Endodontic Partners

endodonticpartners.com

HEALTH HISTORY

☐ SINGLE ☐ MARRIED ☐ DIVORCED
☐ SEPARATED ☐ WIDOWED

NAME

RESIDENCE ADDRESS | CITY | STATE | ZIPCODE

EMPLOYED BY | CITY | STATE | BUSINESS PHONE

PRESENT POSITION | HOME PHONE | PATIENT SOCIAL SECURITY NO.

NAME OF SPOUSE | SPOUSE DOB | SPOUSE SOCIAL SECURITY NO.

REFERRED BY | ADDRESS

SPOUSE EMPLOYED BY | SPOUSE PRESENT POSITION | SPOUSE PHONE NUMBER

WHO WILL PAY FOR THIS ACCOUNT? | NAME OF YOUR DENTAL INSURANCE COMPANY

MEDICAL HISTORY

PHYSICIAN'S NAME | DATE OF LAST PHYSICAL EXAM | PATIENT DOB | AGE

Do you have or have you had any of the following:

- ☐ Any heart problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Circulatory problems
- ☐ Nervous problerns
- ☐ Radiation treatments
- ☐ Excessive bleeding
- ☐ A bad reaction to 'Novocaine'
- ☐ AIDS/HIV
- ☐ Allergies to anesthetics
- ☐ Allergies to medicines or drugs
- ☐ Allergies to: ____________
- ☐ Anemia
- ☐ Any pain or swollen joints
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer or a tumor
- ☐ Diabetes
- ☐ Diabetes
- ☐ Epilepsy (fainting spells, seizures)
- ☐ Frequent headaches
- ☐ Frequent nose bleeds
- ☐ Growing pains
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Malignancies
- ☐ Measles
- ☐ Mumps
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin disease (hives or skin rash)
- ☐ Stroke
- ☐ Swelling of the ankles
- ☐ Thyroid disease
- ☐ Typhoid fever
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Unexplained bruises
- ☐ Venereal disease

Answer the questions:

YES	NO	
☐	☐	Are you taking any medicine? Specify: ____________
☐	☐	Are you being treated by a doctor (physician) now?
☐	☐	Are you pregnant?
☐	☐	Have you taken ACTH or cortisone in the past 12 months?
☐	☐	Gaining or losing weight?
☐	☐	Have you reached Menopause? (change of life)

Blood Pressure: S ______ **/ D** ______ **/** ______

List any operations or major illnesses during the last 2 years:

____

____