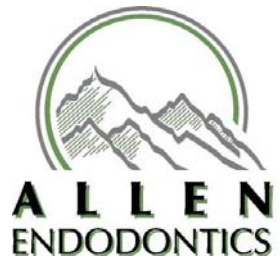


# Patient Health Information

Print Form      Submit by Email



First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Please tell us who referred you to our practice \_\_\_\_\_

General dentist's name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please select "Yes" or "No"

- |                            |                            |                     |                            |                            |                       |                            |                            |                      |
|----------------------------|----------------------------|---------------------|----------------------------|----------------------------|-----------------------|----------------------------|----------------------------|----------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | AIDS/HIV            | <input type="checkbox"/> Y | <input type="checkbox"/> N | Fainting/Dizziness    | <input type="checkbox"/> Y | <input type="checkbox"/> N | Nervous Disorders    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Allergies           | <input type="checkbox"/> Y | <input type="checkbox"/> N | Glaucoma              | <input type="checkbox"/> Y | <input type="checkbox"/> N | Pacemaker            |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Anemia              | <input type="checkbox"/> Y | <input type="checkbox"/> N | Smoking               | <input type="checkbox"/> Y | <input type="checkbox"/> N | Radiation Treatment  |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Arthritis           | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hay Fever             | <input type="checkbox"/> Y | <input type="checkbox"/> N | Radiation Therapy    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Artificial Joints   | <input type="checkbox"/> Y | <input type="checkbox"/> N | Head Injuries         | <input type="checkbox"/> Y | <input type="checkbox"/> N | Respiratory Problems |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma/Emphysema    | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Disease/Angina  | <input type="checkbox"/> Y | <input type="checkbox"/> N | Rheumatic Fever      |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Blood Diseases      | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Murmur          | <input type="checkbox"/> Y | <input type="checkbox"/> N | Rheumatism           |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Bleeding/Hemophilia | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Stent           | <input type="checkbox"/> Y | <input type="checkbox"/> N | Sinus Problems       |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Blood Thinners      | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Surgery/Stroke  | <input type="checkbox"/> Y | <input type="checkbox"/> N | Steroid Treatment    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer              | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hepatitis A, B or C   | <input type="checkbox"/> Y | <input type="checkbox"/> N | Stomach Problems     |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Chemotherapy        | <input type="checkbox"/> Y | <input type="checkbox"/> N | High Blood Pressure   | <input type="checkbox"/> Y | <input type="checkbox"/> N | Stroke               |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Chronic Sinus       | <input type="checkbox"/> Y | <input type="checkbox"/> N | Immunodeficiencies    | <input type="checkbox"/> Y | <input type="checkbox"/> N | Thyroid Treatment    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Chronic Depression  | <input type="checkbox"/> Y | <input type="checkbox"/> N | Jaundice              | <input type="checkbox"/> Y | <input type="checkbox"/> N | TMJ Disorder         |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Chronic Headaches   | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Disease        | <input type="checkbox"/> Y | <input type="checkbox"/> N | Tuberculosis         |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes            | <input type="checkbox"/> Y | <input type="checkbox"/> N | Liver Disease         | <input type="checkbox"/> Y | <input type="checkbox"/> N | Tumors & Growth      |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Epilepsy            | <input type="checkbox"/> Y | <input type="checkbox"/> N | Mental Disorders      | <input type="checkbox"/> Y | <input type="checkbox"/> N | Ulcers               |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Excessive Bleeding  | <input type="checkbox"/> Y | <input type="checkbox"/> N | Mitral Valve Prolapse | <input type="checkbox"/> Y | <input type="checkbox"/> N | Venereal Disease     |

**WOMEN ONLY:** Are you taking any birth control medication?  Y  N  
NOTE: ANTIBIOTICS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES.  
Are you or could you be PREGNANT?  Y  N      If Pregnant: Date due \_\_\_\_\_ Name of OB/GYN \_\_\_\_\_

Have you ever had any complications associated with previous dental treatment?  Y  N  
If Yes, please explain \_\_\_\_\_

Are you currently taking any medications? Please list: \_\_\_\_\_

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel®, Fosamax® or Zometa, within the past twelve years?  Y  N

Have you ever taken Fen-Phen or any other diet drugs?  Y  N      If Yes, please list \_\_\_\_\_

Are you currently under the care of a physician?  Y  N      If Yes, please explain \_\_\_\_\_

Are you allergic to any medication (PENICILLIN, LATEX, ETC.)? Please list \_\_\_\_\_

List past surgeries \_\_\_\_\_

Please list any other allergies that you may have: \_\_\_\_\_

I have read and understood each question, and have answered all of them truthfully and to the best of my knowledge and ability. I will not hold Allen Endodontics or any other employee, including dentists and other staff, of Allen Endodontics responsible for any errors and/or omissions that I may have made in the completion of this form. I understand that if any change occurs in my health I am to report it to the dental office as soon as possible. I understand upon completion of root canal therapy in this office, I MUST RETURN TO MY GENERAL DENTIST FOR PERMANENT RESTORATION.

Signature of patient (parent or guardian if Patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_