PATIENT HEALTH HISTORY

Patient Name:_____ **Physician's Name:**_____

Physician's Address:_____ **Physician's Phone #:**_____

DO YOU HAVE OR HAVE YOU EVER HAD:

Heart Disease	**Yes ____ No ____**	**H.I.V. Positive**	**Yes____ No ____**
Rheumatic Fever	**Yes ____ No ____**	**Hepatitis**	**Yes____ No ____**
High Blood Pressure	**Yes ____ No ____**	**Tuberculosis**	**Yes____ No ____**
Excessive Bleeding	**Yes ____ No ____**	**Liver Disease**	**Yes____ No ____**
Asthma	**Yes ____ No ____**	**Diabetes**	**Yes____ No ____**

Other Diseases:_____
_____

ALLERGIES:

To Aspirin	**Yes ____ No ____**	**To Local Anesthetic (such as Novocaine)**	**Yes ____ No ____**
To Penicillin	**Yes ____ No ____**	**To Codeine**	**Yes ____ No ____**

Other Allergies:_____
_____

Is there any reason for you to be Pre-Med? Yes ____ No ____ If Yes, what for? Mitral Valve Prolapse, Heart Murmur, Hip or Joint Replacement, Rheumatic Fever, Other (Please Circle)

Are you taking medication or drugs: Yes ____ No ____ Medications:_____

Are you pregnant:_____ **Number of months:**_____

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel or Fosamax within the past 12 years? yes_____ no_____

CONSENT-----PLEASE READ AND SIGN:

This is to certify that I, the undersigned, consent to any advisable and necessary endodontic therapy/surgery to be administered by the endodontist or his supervised staff for diagnostic purpose or 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.

I understand that I may need to return to my dentist for permanent restoration of the treated tooth.

_____

Signature (patient/guardian) Relationship to patient Date