Patient Name: _____

List any medication you are currently taking, including over the counter medications:

Medication: _____ Dosage: _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you now have or have you had any of the following conditions listed below?: (Circle) where applicable

AIDS or HIV infection	Epilepsy / Seizures	Low Blood Pressure
Angina	Fainting Spells	Lung Disease
Artificial Joint/ Date _____	Heart Attack	Mitral Valve Prolapse
Artificial Valve	Heart Disease	Palpitations
Asthma	Heart Murmur	Rheumatic Fever
Bleeding Problems	Hepatitis - A B C	Stroke
Chest Pains	High Blood Pressure	Tuberculosis
Diabetes	Liver Disease	Ulcers

Other: _____

Due to any medical condition, (such as artificial joint / joint replacement or heart valve replacement) have you been advised to take an antibiotic before dental cleanings / dental visits? YES NO

Have you been treated by a physician in the last five years?: YES NO

Reason _____ When _____

Are you or have you recently been on any blood thinning medications? YES NO

Are you or have you recently been on any medications for Osteoporosis? YES NO

Have you ever had excessive bleeding requiring special treatment?: YES NO

Have you had a blood transfusion in the last 5 years?: YES NO

ALLERGIES: Do you have an adverse reaction when taking:

Local Anesthetic Aspirin Penicillin Other _____

Do you have a pacemaker?: YES NO

Do you have an allergy to latex?: YES NO

For Women: Are you currently: Pregnant YES NO Month _____

Nursing YES NO

Taking Birth Control YES NO

NOTE: Antibiotics can interfere with the effectiveness of birth control prescriptions. Contact your prescribing physician for instructions if taking a birth control prescription.

I certify that I have read and understand the above health history. I acknowledge that my questions about inquiries set forth have been answered to the best of my knowledge. I will not hold my endodontist or any member of this office responsible for any errors or omissions that I have made in the completion of this form.

Signature:_____ Date: _____/_____/_____

Patient / Guardian/ Parent if patient is a minor