HEALTH HISTORY

Endodontics of Colorado, L.L.C.

PLEASE PRINT Answer all questions by circling Yes (Y) or No. (N). **ALL RESPONSES ARE KEPT CONFIDENTIAL**

Today s Date ______/______/______

1. Are you in good Health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam? ___/___/___
4. Are you now under a physicians care for a .... particular problem .... Y N
5. Have you ever had any serious illnesses, operations or hospitalization? If so, describe: .... Y N

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6. Height ______ Weight______
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? .. Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, ... Y N
     Blood Transfusion, Do you bruise easily/ .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart valve, Pacemaker, Hip, knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
   - S. HIV, AIDS, or ARC? .... Y N

   If you answered YES to any of the conditions, please call prior to your appointment -- premedication may be required.
8. **ARE YOU USING ANY OF THE FOLLOWING?** ......
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .... Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Steroids (Cortisone, etc.)? .... Y N
   - F. Tranquilizers? .... Y N
   - G. Insulin or Oral Anti-Diabetic drug? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drugs? ..... Y N
   - I. Any regular medicine, Pills or Drugs --- either over-the-counter or prescription? If Yes, please list? ..... Y N

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9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia (Novocaine, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbituates? .... Y N
   - D. Aspirin or Ibuprofens? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please list .... Y N

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10. Do you Smoke or Chew Tobacco? .... Y N
    How much per day? ______
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect The care that we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatment? .... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk with the doctor privately about anything? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or <u>is there any chance</u> you might be Pregnant? .... Y N
    - B. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss any health history with my doctor.

DATE ______ SIGNATURE OF PERSON COMPLETING HEALTH HISTORY ______ DOCTOR'S INITIALS ______

MEDICAL UPDATE: I have read my Health History dated ______/______/______ and confirm that it adequately states past and present conditions.

DATE ______ EXCEPTIONS OR CHANGES ______ PATIENT'S SIGNATURE ______ DOCTOR'S INITIALS ______

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