LAS VEGAS ENDODONTICS

Health History

PATIENT INFORMATION

First Name		MI		Last Name		Birth Date	

HEALTH HISTORY

Physician's Name		City		Phone	
Are you under a physician's care now or during the last 2 years?					❑ Yes ❑ No
Preferred Pharmacy		Location		Phone	
Have you ever had an injury to the head, mouth or teeth?					❑ Yes ❑ No
If yes, please explain					
Have you ever been advised to take an antibiotic prior to a dental procedure due to a heart problem or artificial joint?					❑ Yes ❑ No
If yes, please explain					

Have you recently had any of the following symptoms?

❑ Bloody Sputum ❑ Hoarseness ❑ Fatigue ❑ Night Sweats
❑ Chest Pain ❑ Loss of Appetite ❑ Unexplained Weight Loss

Please select YES if you have, or have had, any of the following conditions?

	Yes	No		Yes	No		Yes	No
Heart Disease, Surgery or Attack			Epilepsy or Seizures			Asthma		
High Blood Pressure			Fainting or Dizzy Spells			Hepatitis, Jaundice, Liver Disease		
Angina Pectoris			Kidney Disease			AIDS or HIV Positive		
Congenital Heart Lesions			Diabetes			Sexually Transmitted Disease		
Artificial Heart Valve			Ulcer or Stomach Trouble			Drug or Alcohol Addiction		
Heart Pacemaker			Thyroid Disease			Cold Sores		
Artificial Joint			Tuberculosis (TB)			Herpes		
Hemophilia or Excess Bleeding			Breast Cancer			Arthritis		
Stroke			Multiple Myeloma			Osteoporosis		
Glaucoma			Other Cancer or Tumors			Pain in Jaw Joint (TMJ)		
Psychiatric Treatment			Chemo or Radiation Therapy			Allergies		
Mental Disorder			Lung Disease			Sinus Trouble		

Is there any disease, condition, or problem that you think our office should know about that is not listed above? ❑ Yes ❑ No

Please explain/clarify any conditions selected above along with any other condition not listed.

MEDICATIONS

Have you ever taken any of the following medications for Osteoporosis or Cancer Therapy? ❑ Yes ❑ No

❑ Fosamax ❑ Aredia ❑ Boniva ❑ Zometa ❑ Actonel

Please list all medications, over the counter and herbal supplements, that you are currently taking (include medication name, dosage and frequency):

ALLERGIES

Are you allergic to, or had an unusual reaction to any of the following?

	Yes	No		Yes	No		Yes	No
Dental Local Anesthetics			Latex			Penicillin or other Antibiotics		
Aspirin or Tylenol Compounds			Anti-inflammatory Drugs			Codeine or other Narcotics		
Motrin, Advil, Aleve, etc.			Barbiturate or Tranquilizers			Other		

Please list any allergy/reaction not listed.

Women					
Are you pregnant?	❑ Yes ❑ No	**If yes, how many months?**		**Are you taking birth control pills?**	❑ Yes ❑ No
WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.					

FORM COMPLETION

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any changes in my health or medication.

Health Care Records Retention: As per regulations of the Nevada State Board of health pursuant *NRS 629.051*, heath care offices shall retain the patient's health care records and laboratory records for five years after production. Also, that no records are to be destroyed for patients under the age of 23. Patients may request a copy of records up to the date of the fifth year by written request. All other documents will be professionally destroyed.

Signature of Patient, Parent or Guardian:		**Date:**	

IF PATIENT IS A MINOR

Form signed by:		**Relationship to Patient:**	