EMPIRE ENDODONTICS
Where Endo is Fun!

# HEALTH HISTORY

Patient Printed: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________

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Date of Birth: ____________________ When was your last dental exam? ______________ (Year)

Date of last health care exam: ____________________ What was this exam for? ______________

Have you been hospitalized or had surgery? (PLEASE CIRCLE) Yes No If yes, reason: ______________

Are you currently receiving care? Yes No If yes, nature of care: ______________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. Name: ______________________________ Phone number: ______________
2. Name: ______________________________ Phone number: ______________
3. Name: ______________________________ Phone number: ______________

For the following questions, circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your response. Our team may ask additional questions concerning your health.

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| Blood Disorders | Yes | No | Hepatitis, Any Form | Yes | No |
| Arthritis, Rheumatism or other inflammatory disease | Yes | No | Joint Replacement | Yes | No |
| Asthma, COPD or other Lung Diseases | Yes | No | If yes, when was it placed? ______________ | | |
| Abnormal Bleeding | Yes | No | If yes, did your medical provider recommend an antibiotic before dental treatment? | Yes | No |
| Cancer or Tumor | Yes | No | | | |
| If yes, what type of Cancer? __________ When? __________ | | | Kidney Disease | Yes | No |
| Sinus Problems | Yes | No | Liver Disease (including Jaundice) | Yes | No |
| Emphysema or other Respiratory/Lung Illnesses | Yes | No | Sore/Enlarged Lymph Nodes | Yes | No |
| Epilepsy | Yes | No | Heart murmur | Yes | No |
| Fainting or Dizzy Spells | Yes | No | Psychiatric Therapy | Yes | No |
| Glaucoma | Yes | No | Previous Biopsies | Yes | No |
| Previous Bacterial Endocarditis | Yes | No | Radiation or Chemotherapy Treatment | Yes | No |
| Heart Valve (artificial) or Heart Transplant | Yes | No | Renal Dialysis | Yes | No |
| Congenital Heart Disease | Yes | No | Slow-Healing Mouth Sores | Yes | No |
| Heart Disease, Heart Attack, Heart Surgery, Angina | Yes | No | Unintentional Weight Loss/Gain | Yes | No |
| Heart Stent | Yes | No | H.I.V. Infection/AIDS | Yes | No |
| If yes, when was it placed? ______________ | | | Venereal Disease | Yes | No |
| Migranes | Yes | No | Thyroid | Yes | No |
| Anemia | Yes | No | Recurrent Illnesses | Yes | No |
| Rheumatic Fever | Yes | No | Dry Mouth | Yes | No |
| Tuberculosis | Yes | No | Other Conditions | Yes | No |
| Stroke/T.I.A. | Yes | No | Eye Problems | Yes | No |

**Are you taking any of these medications?**

| Medication | | | Medication | | |
|---|---|---|---|---|---|
| Blaxin® (Clarithromycin) | Yes | No | Antacids | Yes | No |
| Cardizem® (Diltiazem) or Calan, Isoptin® (Verapamil) | Yes | No | St. John's Wort or Kava-Kava | Yes | No |
| Barbiturates (any) | Yes | No | Dilantin® or Tegretol® | Yes | No |
| Diflucan® (Fluconazole) or Sporanox® (Itraconazole) | | | | Yes | No |
| Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? | | | | Yes | No |
| If so, when did the treatment begin? ______________ When did the treatment end? ______________ | | | | | |

Patient Name Printed: ______________________ Date: __________

| Have you traveled outside of the US recently? | Yes | No | If yes, where? | Yes | No |
|---|---|---|---|---|---|
| Have you been in contact with anyone exposed, suspected to have been exposed, or has been diagnosed with Coronavirus/COVID-19? | Yes | No | Have you recently experienced a fever, cough, or difficulty breathing? | Yes | No |

Please list any medications you are currently taking and dosages:

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

Please list any dietary or herbal supplements you are taking and for what purpose:

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

Do you use recreational drugs? Yes No If so, which ones? ______________________

**T.M.D.**

TMJ problems? Yes No Explain ______________________

**WOMEN**

Are you pregnant? ........................................ Yes No

If no, are you planning a pregnancy in the near future? .................. Yes No

Are you a nursing mother? ........................................ Yes No

Are you taking birth control pills? ........................................ Yes No

**ABNORMAL BLOOD PRESSURE?** (PLEASE CIRCLE)

Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"? Yes No

What is your normal blood pressure? S __________ /D __________

**ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:**

A. Local anesthetics or epinephrine ........................................ Yes No

B. Penicillin or other antibiotics ........................................ Yes No

C. Aspirin, Ibuprofen or Tylenol® ........................................ Yes No

D. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives ................ Yes No

E. Latex or Metals ........................................ Yes No

F. Other: (Please specify) ______________________

**DIABETES** Yes No If so, please answer questions below.

Circle one: Oral Meds Insulin

Circle one: Type I Type II

A1C? __________

Average Blood Glucose reading? __________

**TOBACCO, ALCOHOL, DRUGS**

| Do you use tobacco? | Yes | No |
|---|---|---|
| If yes, circle type: Smoke Chew How much per day? __________ For how long? __________ | | |
| Do you consume alcohol? | Yes | No |