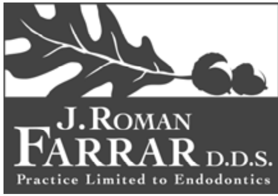

Health History

1809Northpointe Lane
Suite 104
Ruston, LA 71270
318.255.3636 (ENDO)
Fax: 318.255.3033

Patient Name ____ Date ______________________

Do you have, or have you had, any of the following conditions?

Cardiovascular Disease

- ☐ High Blood Pressure
- ☐ Arteriosclerosis
- ☐ Heart Attack. If YES, then when___________________
- ☐ Heart By-Pass Surgery. If YES, then when___________
- ☐ Prosthetic Heart Valves
- ☐ Congenital Heart Malformations
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congestive Heart Failure (CHF)
- ☐ Other. Please explain: _________________________

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Other Medical Conditions

- ☐ Diabetes. If YES, are you taking insulin? ____________
- ☐ Blood Transfusion
- ☐ Hepatitis or Liver Disease
- ☐ Stomach Ulcers
- ☐ Kidney Problems or Dialysis
- ☐ Arthritis or Rheumatism
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ HIV or AIDS
- ☐ Epilepsy
- ☐ Recurring Fainting Spells
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Cancer. If YES, are you currently on Chemotherapy or Radiation? _____________________
- ☐ Joint Prosthesis (hip, knee, etc.)
- ☐ Osteoporosis
- ☐ TMJ Disorder
- ☐ Sinus Problems/Seasonal Allergies
- ☐ Asthma
- ☐ Eye Disease/Glaucoma
- ☐ Drug or Alchohol Addiction
- ☐ Psychiatric Treatment
- ☐ Antibiotic Pre-medication Prior to Dental Treatment
- ☐ Other. Please explain: ___________________

____

Allergies

- ☐ Penicillin/Antibiotics
- ☐ Sufla Drugs
- ☐ Codeine
- ☐ Iodine
- ☐ Aspirin
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Other. Please explain: ___________________

____

Are you currently under a physician's care? Y N If yes, please explain: ______________________________

Have you ever been hospitalized or had a major operation? Y N If yes, please explain: ______________________________

Are you currently taking any medications, pills, or drugs? Y N If yes, please explain: ______________________________

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____

____

For women only: Are you pregnant or trying to get pregnant? Y N
Are you nursing? Y N
Are you taking oral contraceptives:? Y N

Have you had any serious illness or condition not mentioned above? Y N If Yes, please explain: ______________________________

____

Is this dental visit related to an accident? Y N Was the accident work related? Y N Please explain: ______________________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health, It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian ________________________________ DATE ____________________