Health History

Are you currently under the care of a physician? Yes No
Physician's Name _____
For what condition? _____
Address & phone # _____
Are you experiencing any dental pain now? Yes No
Did your Dentist or referring Doctor prescribe any medication? If yes, what medication?_____
_____

A. Cardiovascular System – <u>Circle Yes or No</u>

1. High or low blood pressure …….. Yes No
2. Heart attack/Heart Surgery…… Yes No
   If yes, When?.....
3. Heart murmur (congenital heart disease)… Yes No
4. Chest pain upon exertion (angina) …… Yes No
5. Rheumatic heart disease or fever ……... Yes No
6. Stroke …… Yes No
   If yes, When? .....

B. Nervous System – circle all that apply

1. Epilepsy, convulsions, seizures, or fainting. Yes No
2. Neuritis, neuralgia, or numbness …… Yes No

C. Respiratory System – circle all that apply

1. Tuberculosis …… Yes No
2. Sinus trouble, hay fever, allergies ……. Yes No
3. Pneumonia, asthma, or emphysema ……...Yes No
4. History of smoking …… Yes No

D. Genitourinary and Gastrointestinal Systems

1. Kidney disease ……... Yes No
2. Stomach or intestinal problems ……..Yes No
3. Liver disease, jaundice, or hepatitis …… Yes No
4. Ulcers, reflux disease …… Yes No
5. Eating disorders …… Yes No

E. Endocrine System – circle all that apply

1. Diabetes (Type I or Type II) Yes No
2. Thyroid disease …… Yes No

F. Bones and Joints – circle all that apply

1. Osteo – or rheumatoid arthritis …… Yes No
2. Joint replacement …….. Yes No
3. Back, neck, or jaw injury …… Yes No

G. Blood-Lymphatics – circle all that apply

1. Blood disorder or anemia …….. Yes No
2. Abnormal bleeding …… Yes No

H. Infectious Diseases – circle all that apply

1. Hepatitis (A, B, C, or other) …… Yes No
2. AIDS, HIV…… Yes No

Emergency contact:_____
Relationship & phone # _____

I. Radiation History

1. Have you ever had radiation therapy? ….Yes No
   When? _____

J. Medication

Are you taking any of the following?

1. Antibiotics or sulfa drugs …….. Yes No
2. Anticoagulants (blood thinners) …… Yes No
3. Medicine for high blood pressure …….. Yes No
4. Cortisone (steroids) …….. Yes No
5. Anti-depressants …… Yes No
6. Antihistamines …….. Yes No
7. Aspirin on a regular, ongoing basis …… Yes No
8. Insulin or other anti-diabetic meds …… Yes No
9. Digitalis or other heart medications … Yes No
10. Nitroglycerin …….. Yes No
11. Chemotherapy …… Yes No
12. History of diet pills (Fen-phen, etc.) … Yes No
13. Inhaler, prescription or OTC ……Yes No
14. Please list other medications:

_____>>>

K. Allergies

Are you allergic to or have you had a reaction to:

1. Penicillin …… Yes No
2. Sulfa …….. Yes No
4. Local anesthetics (Novocaine, etc.) …….Yes No
5. Latex …… Yes No
6. Aspirin …….. Yes No
7. Codeine …… Yes No
8. Other :_____

L. Women

1. Are you pregnant? …… Yes No
2. Breast cancer …… Yes No
3. Using birth control? …….. Yes No

Do you have any disease, condition, or Health problem not listed in the previous questions?
…….. Yes No
List _____

*My signature certifies that the **health information** provided is complete and accurate. I agree to inform Broken Arrow Endodontics of any changes in my medications or health prior to any future treatment. I have reviewed a copy of this office's **Notice of Privacy Practices** (please read the last couple of pages) and I have read and understood also Broken Arrow Endodontics' **Financial Policy** (please read the last couple of pages), & agree to abide by it, and will pay today with one of the following*:
NO CHECKS ACCEPTED □ I would like to apply to CareCredit® for financing.

Signature (patient / guardian): _____ Date _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
□ Individual refused to sign □ Emergency situation prevented / prohibited obtainined acknowledgement □ Communication barriers prohibited obtaining acknowledgement □ Other