VALLEY ENDODONTICS, PC

PATIENT HEALTH QUESTIONS

Patient Name: _____ Date _____

1. **HAVE YOU EVER HAD ROOT CANAL TREATMENT?** _____ Y N
2. **DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:**
   - A. HEART TROUBLE; RHEUMATIC FEVER; MITRAL VALVE PROLAPSE; ARTIFICIAL HEART VALVE, OR HEART MURMUR? **(IF SO, CIRCLE WHICH ONE)** _____ Y N
   - B. HIGH BLOOD PRESSURE? _____ Y N
   - C. DIABETES? _____ Y N
   - D. KIDNEY DISEASE ? _____ Y N
   - E. HEPATITIS, LIVER DISEASE ? _____ Y N
   - F. TUBERCULOSIS ? _____ Y N
   - G. HERPES ? _____ Y N
   - H. AIDS, HIV POSITIVE OR POSITIVE FOR AIDS VIRUS? **(CIRCLE)** _____ Y N
   - I. ARTIFICIAL JOINTS OR IMPLANTS ? _____ Y N
   - J. LUNG DISEASES; ASTHMA BRONCHITIS, EMPHYSEMA? **(CIRCLE)** _____ Y N
   - K. EPILEPSY, MULTIPLE SCLEROSIS OR GLAUCOMA? **(CIRCLE)** _____ Y N
   - L. ULCER ? _____ Y N
3. **HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE:**
   - **A. TMJ** (TEMPOROMANDIBULAR JOINT DISEASE) OR **CLICKING** OF THE **JAW? (CIRCLE)** _____ Y N
   - **B. DIFFICULTY OPENING** OR **MUSCLE SPASMS** IN YOUR JAW? **(CIRCLE)** _____ Y N
4. **DIFFICULTY BREATHING** THROUGH YOUR NOSE? _____ Y N
5. HAVE YOU EVER HAD **PROLONGED BLEEDING** FROM AN INJURY, TOOTH EXTRACTIONS, etc.? _____ Y N
6. HAVE YOU EVER HAD A **REACTION** FROM A **LOCAL ANESTHETIC?** _____ Y N
7. HAVE YOU EXPERIENCED ANY **ILLNESS** OR **COMPLICATIONS** FOLLOWING **DENTAL TREATMENT**? Y N

   EXPLAIN: _____
8. ARE YOU **ALLERGIC** TO ANY **DRUGS, MEDICATIONS** OR TO **LATEX? (LIST)** _____ Y N

   _____
9. ARE YOU TAKING ANY **DRUGS, MEDICATIONS OR VITAMINS** AT THIS TIME? **(LIST)** _____ Y N

   _____
10. ARE YOU OR HAVE YOU **EVER TAKEN MEDICATION TO HELP PREVENT OSTEOPOROSIS,** SUCH AS:

    CIRCLE: FOSAMAX ACTONEL BONIVA ZOMETA AREDIA OR OTHER BISPHOSPHONATES
11. DO YOU HAVE A HISTORY OF **CHEMICAL DEPENDENCY?** _____ Y N
12. DID YOU HAVE ANY **ALCOHOLIC BEVERAGES** TODAY? _____ Y N
13. DO YOU HAVE, OR HAVE YOU RECENTLY HAD ANY EVIDENCE OF **INFECTIONS** OR **SORE THROAT?** _____ Y N
14. HAVE YOU BEEN **HOSPITALIZED** OR UNDER THE CARE OF A PHYSICIAN **THIS PAST YEAR?** _____ Y N
15. DO YOU HAVE ANY **DISEASE, CONDITION** OR PROBLEM **I SHOULD KNOW ABOUT?** _____ Y N

    EXPLAIN: _____ Y N
16. **WOMEN:** ARE YOU PREGNANT? _____ MONTHS _____ **TAKING BIRTH CONTROL PILLS?** _____ Y N
17. WHAT IS THE IMPRESSION OF YOUR PRESENT HEALTH: ____**GOOD** ____**FAIR** ____**POOR**

MY ANSWERS TO THE ABOVE QUESTIONS ARE TRUE TO THE BEST OF MY KNOWLEDE

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____