Health History

Donald G. Anderson, D.D.S., M.S.
PRACTICE LIMITED TO ENDODONTICS

Patient Name _____ Sex M F

Who referred you to our office? _____

Who is your Dentist? _____

1. Do you presently have a toothache? Yes ____ No ____
2. Have you ever had Endodontic (Root Canal) Treatment? Yes _____ No _____
3. Are you in good health? Yes _____ No ____

   Who is your Physician (Medical Doctor) _____
4. Are you currently under the care of a physician? Yes _____ No _____

   If Yes, please explain _____
5. If female, are you pregnant? Yes ____ What Month? _____ No _____
6. Have you ever had an unusual or allergic reaction to things such as Latex, Penicillin, Aspirin, Codeine, Novocaine, etc.? _____

   _____
7. Please list **all** medicines you currently take. _____

   _____
8. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax or Zometa,

   within the past twelve years? Yes _____ No _____
9. Is there any other information that we should know about your health? _____

_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

Heart Attack	AIDS (HIV+)	Diabetes	Emphysema
Heart Condition	Anemia	Glaucoma	Epilepsy or Seizures
Heart Murmur	Hemophilia	Kidney Trouble	Fainting or Dizzy Spells
Chest Pains (Angina)	Bleeding Disorders	Liver Disease	Nervous Disorders
Heart Surgery	Stroke	Hepatitis A	Thyroid Disease
Mitral Valve Prolapse	Bruise Easily	Hepatitis B	Cancer or Other Tumor
Heart Pacemaker	Lung Disease (COPD)	Yellow Jaundice	Radiation Therapy
High Blood Pressure	Shortness of Breath	Alcoholism	Chemotherapy
Swelling of Ankles	Asthma or Hay Fever	Drug Addiction	Cold Sores
Rheumatic Fever	Tuberculosis (TB)	Arthritis or Fibromyalgia	Herpes
Ulcerative Colitis	Digestive Disorders (IBD)	Pain in jaw joints (TMJ)	Prosthetic Joint Replacement

I, THE UNDERSIGNED, BEING THE PATIENT OR THE PARENT OR GUARDIAN OF ABOVE MINOR PATIENT, CONSENT AFTER CONSULTATION WITH THE DOCTOR, TO THE PERFORMING OF WHATEVER PROCEDURE MAY BE DETERMINED NECESSARY BY THE DOCTOR. I AUTHORIZE AND REQUEST THE ADMINISTRATION OF SUCH DRUGS AND/OR ANESTHETICS AS MAY BE DEEMED ADVISABLE BY THE DOCTOR. I ALSO UNDERSTAND THAT UPON COMPLETION OF ROOT CANAL THERAPY IN THIS OFFICE, I WILL BE REFERRED TO MY DENTIST FOR A FINAL RESTORATION (E.G. CROWN). I CERTIFY THE ABOVE HEALTH HISTORY TO BE CORRECT. I AUTHORIZE RELEASE OF MY TREATMENT RECORD IN ACCORDANCE WITH HIPAA REGULATIONS.

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SIGNATURE PATIENT/PARENT/GUARDIAN (CIRCLE ONE) DATE