

**ENDODONTIC ASSOCIATES  
PATIENT HEALTH QUESTIONS**

**Bring the completed form with you  
to your appointment**

PATIENT NAME \_\_\_\_\_

CHART# \_\_\_\_\_

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. <b>HAVE YOU EVER HAD ROOT CANAL TREATMENT?</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. <b>DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:</b>   |                          |                          |
| a. HEART TROUBLE; RHEUMATIC FEVER; MITRAL VALVE PROLAPSE;. ARTIFICIAL HEART VALVE ,<br>OR HEART MURMUR? <b>(IF SO, CIRCLE WHICH ONE)</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. HIGH BLOOD PRESSURE? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. DIABETES? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. KIDNEY DISEASE? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. HEPATITIS, LIVER DISEASE? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. TUBERCULOSIS? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. HERPES? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. AIDS, HIV POSITIVE OR POSITIVE FOR AIDS VIRUS? <b>(CIRCLE)</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. ARTIFICIAL JOINTS OR IMPLANTS? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. LUNG DISEASES; ASTHMA, BRONCHITIS, EMPHYSEMA? <b>(CIRCLE)</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. EPILEPSY, MULTIPLE SCLEROSIS OR GLAUCOMA? <b>(CIRCLE)</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. ULCER? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. <b>HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE:</b>   |                          |                          |
| a. <b>TMJ</b> (TEMPOROMANDIBULAR JOINT DISEASE) OR <b>CLICKING</b> OF THE <b>JAW?</b> <b>(CIRCLE)</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <b>DIFFICULTY OPENING</b> OR <b>MUSCLE SPASMS</b> IN YOUR JAW? <b>(CIRCLE)</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. <b>DIFFICULTY BREATHING</b> THROUGH YOUR NOSE? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HAVE YOU EVER HAD <b>PROLONGED BLEEDING</b> FROM AN INJURY, TOOTH EXTRACTIONS , etc? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. HAVE YOU EVER HAD A <b>REACTION</b> FROM A <b>LOCAL ANESTHETIC?</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. HAVE YOU EXPERIENCED ANY <b>ILLNESS</b> OR <b>COMPLICATIONS</b> FOLLOWING <b>DENTAL TREATMENT</b> OF ANY KIND? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EXPLAIN;</b> _____  |                          |                          |
| 8. ARE YOU <b>ALLERGIC</b> TO ANY <b>DRUGS, MEDICATIONS</b> OR TO <b>LATEX?</b> <b>(LIST)</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| _____  |                          |                          |
| 9. ARE YOU TAKING ANY <b>DRUGS, MEDICATIONS</b> OR <b>VITAMINS</b> AT THIS TIME? <b>(LIST)</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| _____  |                          |                          |
| 10. ARE YOU OR HAVE YOU <b>EVER TAKEN</b> <b>MEDICATION</b> TO <b>HELP PREVENT OSTEOPOROSIS</b> , SUCH AS;<br><b>CIRCLE:</b> <b>FOSAMAX ACTONEL BONIVA ZOMETA AREDIA</b> OR OTHER <b>BISPHOSPHONATES</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. DO YOU HAVE A HISTORY OF <b>CHEMICAL DEPENDENCY?</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. DID YOU HAVE ANY <b>ALCOHOLIC BEVERAGES</b> TODAY? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. DO YOU HAVE, OR HAVE YOU RECENTLY HAD ANY EVIDENCE OF <b>INFECTIONS</b> OR <b>SORE THROAT?</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. HAVE YOU BEEN <b>HOSPITALIZED</b> OR UNDER THE <b>CARE OF A PHYSICIAN</b> THIS PAST YEAR? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. DO YOU HAVE ANY <b>DISEASE, CONDITION</b> OR <b>PROBLEM I SHOULD KNOW ABOUT?</b> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(EXPLAIN)</b> _____   |                          |                          |
| 16. <b>WOMEN:</b> ARE YOU PREGNANT? _____ MONTHS _____ <b>TAKING BIRTH CONTROL PILLS?</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. <b>HAVE YOU EVER HAD A ROOT CANAL</b> BY ONE OF OUR DOCTORS? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| IF YES, BY WHOM? _____ DO YOU KNOW WHEN? _____   |                          |                          |
| 18. WHAT IS THE IMPRESSION OF YOUR PRESENT HEALTH: <input type="checkbox"/> <b>GOOD</b> <input type="checkbox"/> <b>FAIR</b> <input type="checkbox"/> <b>POOR</b>  |                          |                          |

**MY ANSWERS TO THE ABOVE QUESTIONS ARE TRUE TO THE BEST OF MY KNOWLEDGE.**

PATIENT/ GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ATTENDING DOCTOR SIGNATURE \_\_\_\_\_