Clifton Endodontics
Health History

Patient Information

Name _____ Date of Birth _____ Social security number _____

Address _____ City _____ State _____ Zip _____

Home phone (____)_____ Business phone (_____)_____ Cell Phone (_____) _____

Marital Status _____ Spouse's name _____ Your Occupation _____

Email: _____ Would you like to receive appointment reminders via text? Y N

Dental Insurance: _____ Subscriber Name: _____ Subscriber Date of Birth: ___/___/___ ID# _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Referred by Dr. _____ Emergency contact and telephone number _____

Today's visit

Are you having any pain? If so, please describe the pain. (what causes your pain, duration, frequency, etc).....

.....

Present health history

Are you in good health?.....(Y) (N)

Are you under a doctor's care now? If so, please specify reason for treatment: .....

.....

Are you taking any medications at the present time? If so, please list all medications including aspirin, vitamins, birth control pills, etc

.....

.....

Have you ever taken medications known as bisphosphonates such as ZOMETA or AREDIA.....(Y) (N)

Have you ever had any joint replacement surgeries that would require you to **premedicate prior to dental procedures?** (Y) (N)

Are you on a Blood Thinner Medication? (Y) (N)

PLEASE CIRCLE ANY CONDITIONS THAT YOU NOW HAVE OR HAVE HAD IN THE PAST:

Rheumatic fever	Y N	Cancer	Y N	Thyroid disease	Y N
Heart murmur	Y N	Radiation therapy	Y N	Ulcers	Y N
Heart problems	Y N	Chemotherapy	Y N	Swollen ankles	Y N
Heart attack	Y N	Stroke	Y N	Anemia	Y N
Mitral valve prolapse	Y N	Diabetes	Y N	Sinus problems	Y N
Pacemaker	Y N	HIV or AIDS	Y N	**TMJ problems**	Y N
High blood pressure	Y N	Hepatitis	Y N	Headaches	Y N
Asthma	Y N	Tobacco use	Y N	Dry mouth	Y N
Arthritis	Y N	Alcohol use	Y N	Fainting	Y N
Tuberculosis	Y N	Unexplained fever	Y N	Are you pregnant?	Y N
Chest pain	Y N	Night sweats	Y N	Other medical problems (List)	
Kidney disease	Y N	Glaucoma	Y N		
Liver disease	Y N	Blood transfusions	Y N		
Seizures	Y N	Gastrointestinal problems	Y N	_____	

Are you **allergic** to any of the following (please circle)

Penicillin Antibiotics Aspirin Codeine Latex Local Anesthetics (Novocaine)

Please list all other **allergies**.....

Please list any hospitalizations:.....

.....

Name of medical doctor:.....Date of last visit:.....Telephone number.....

Is there anything that should be known about your health or previous dental visits? (please specify) .....

.....

Patient Signature:.....Date:.....

REVIEWED BY DOCTOR: _____ DATE: _____