

**Eastern Idaho Endodontics**

**HEALTH HISTORY**

**PATIENT NAME:** \_\_\_\_\_

<b>Current Medical Treatment</b>		<b>Allergies</b>	<b>Medications</b>
<input type="checkbox"/> Insulin Resistant <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Respiratory/Asthma <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Circulatory <input type="checkbox"/> Anemia/Bleeding <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Diabetes/Kidney <input type="checkbox"/> Herpes <input type="checkbox"/> Thyroid/Hormonal <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Smoke <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cancer/Tumor <input type="checkbox"/> Radiation/Chemo <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Fatigue <input type="checkbox"/> Swelling	<input type="checkbox"/> Ulcers/Digestive <input type="checkbox"/> Migraine/Headaches <input type="checkbox"/> Epilepsy/Fainting <input type="checkbox"/> Glaucoma/Visual <input type="checkbox"/> Mental/Neural <input type="checkbox"/> Immunocompromised <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Alcoholism/Addiction <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> TMJ <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur/Defect <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart Attack/Stroke <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Prosthetic Implant <input type="checkbox"/> Any Transplant <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Arthritis <input type="checkbox"/> <b>No Medical Conditions</b>	<input type="checkbox"/> Penicillin <input type="checkbox"/> Antibiotics <input type="checkbox"/> Aspirin <input type="checkbox"/> Tylenol <input type="checkbox"/> Ibuprofen <input type="checkbox"/> NSAIDS <input type="checkbox"/> Codeine <input type="checkbox"/> Narcotics <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> LATEX <input type="checkbox"/> Valium/Tranquilizers <input type="checkbox"/> Nitrous (laughing gas) <input type="checkbox"/> Food <input type="checkbox"/> Bleach <input type="checkbox"/> Iodine/Seafood <input type="checkbox"/> Sulfa <input type="checkbox"/> <b>No Allergies</b>	<input type="checkbox"/> Antibiotics <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Heart Medicine <input type="checkbox"/> Aspirin <input type="checkbox"/> Cortisone/Steroids <input type="checkbox"/> Blood Thinner <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Hormone <input type="checkbox"/> Thyroid <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Insulin <input type="checkbox"/> Ulcer/Nexium <input type="checkbox"/> Bone Related <input type="checkbox"/> Antidepressants <input type="checkbox"/> Tagament <input type="checkbox"/> Insulin Resistance <input type="checkbox"/> Cholesterol <input type="checkbox"/> Other Medications: _____ _____ <input type="checkbox"/> <b>No Medications</b>

\*Do you require a PRE-MED (antibiotic) prior to dental treatment, as recommended by your physician?  
 (i.e joint replacement, heart issues, etc.)  Yes  No

\*Women: Are you pregnant? Yes No Maybe

**Please add any other information that we should know about that could interfere or affect your treatment:** \_\_\_\_\_

Notes/Other Allergies, Conditions, Medications

\_\_\_\_\_

\_\_\_\_\_

The information above is correct to the best of my knowledge.

\_\_\_\_\_  
**Signature of Patient\***

\_\_\_\_\_  
**Date**

\*All signatures must be by parent/guardian if patient is under the age of 18.