Eastern Idaho Endodontics

HEALTH HISTORY

PATIENT NAME: _____

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

*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.