THREE RIVERS ENDODONTICS

HEALTH INFORMATION

Date: _____ Date of last dental visit: _____

Patient Name: _____
Last *First* *M.I.* *(Preferred Name)*

Reason for today's visit: _____

Y	N		If Yes, please explain :
☐	☐	Are you currently under the care of a physician?	
☐	☐	Have you had a serious illness, operation or have been hospitalized in the last 5 years?	
☐	☐	Are you taking, have you ever taken or are scheduled to take any of the following: Alendronate (Fosamax), Risedronate (Actonel), Pamidronate (Aredia), Zoledronate (Zometa) for Osteoporosis, Paget's disease, Bone pain or Hypercalacemia	
☐	☐	Have you had an orthopedic total joint replacement (hip, knee, elbow) and if so, when?	
☐	☐	Have you ever had any complications following dental treatment?	
☐	☐	Do you have any health problems that need further clarification?	

Name of primary care physician : _____ Phone # : _____

Date of last physical exam : _____

Have you ever had any of the following? *(Please check all that apply)*

- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Artificial heart valve
- ☐ Rheumatic fever
- ☐ Cardiovascular disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart defects
- ☐ Pacemaker
- ☐ Stroke
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Hemophilia
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Systemic lupus
- ☐ Asthma
- ☐ Sinus trouble
- ☐ COPD/Emphysema
- ☐ Tuberculosis
- ☐ Cancer *(type)* _____
- ☐ Chemotherapy/Radiation
- ☐ GI Ulcers
- ☐ Glaucoma
- ☐ Hepatitis *(type)* _____
- ☐ Liver disease
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Seizures
- ☐ Neurological disorders
- ☐ Mental health disorders
- ☐ Diabetes: Type I / II
- ☐ Thyroid disorders
- ☐ Kidney disease
- ☐ Substance abuse
- ☐ TMJ/TMD
- ☐ Other: _____

Women Only :
- ☐ Currently pregnant
- ☐ Due date: _____
- ☐ Nursing
- ☐ Taking birth control pills

Allergies :
- ☐ Local anesthetics
- ☐ Aspirin
- ☐ Penicillin/other antibiotics
- ☐ Sulfa drugs
- ☐ Codeine or other narcotics
- ☐ Metals
- ☐ Latex/rubber
- ☐ Bleach
- ☐ Other allergies: _____

List below all prescriptions or over-the-counter medications you are currently taking:

Medication	Dosage	Medication	Dosage

(If taking additional medications, please add to return side of sheet)

To the best of my knowledge, all the preceding answers and information provided are true and correct.
If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____ _____

Signature of patient, parent, or guardian *Date* *Doctor's initials* *Date*

Please see reverse side if you need to update medical history or add additional information.

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HEALTH INFORMATION UPDATE

Additional Medication	Dosage	Office Use

Date	Health Changes	Initials	Dr's. Initials

Additional Information