

PATIENT HEALTH HISTORY

Name: \_\_\_\_\_ Date of Birth (dd/mm/yyyy): \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

General Dentist: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have insurance coverage\*? YES NO

If so, Insurance Provider/Policy: \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_

Would you consider yourself to be in good health? YES NO

Any changes in health in the last year? (Please explain): \_\_\_\_\_

\_\_\_\_\_

Do you smoke? YES NO If so, how much? \_\_\_\_\_ For how many years? \_\_\_\_\_

Have you had any allergic or adverse reactions to the following:

Medications (please list)	Latex/Rubbers/Metals	Other (food, dyes, hayfever..)

Do you have, or have had, any of the following conditions:

	YES	NO		YES	NO
High Blood Pressure			Artificial Joint		
Stroke			HIV/AIDS		
Hepatitis A B or C (please circle)			Hemophilia		

	YES	NO		YES	NO
Jaundice			Asthma /COPD		
Tuberculosis			Psychiatric Treatment		
Heart Murmur			Epilepsy/seizures		
Mitral Valve Prolapse			Kidney Disease		
Rheumatic or Scarlet Fever			Drug or Alcohol Addiction/Dependency		
Cancer			Leukemia		
Diabetes			Osteoporosis		
Venereal disease			Liver disease		

Comments: \_\_\_\_\_

Any medical conditions not listed: \_\_\_\_\_

Any medical conditions that run in your family: \_\_\_\_\_

Have you ever been hospitalized? YES NO If so, why? \_\_\_\_\_

WOMEN:		Fourth Ave		Due Date: _____
Are you Pregnant?	YES NO			
Are you Breastfeeding?	YES NO			

Are you taking any vitamins or herbal supplements? (Please list) \_\_\_\_\_

Recreational Drug Use: YES NO If yes, please elaborate: \_\_\_\_\_

Weekly Alcohol intake: \_\_\_\_\_

Have you ever had root canal/endodontic therapy? YES NO

Clinician: \_\_\_\_\_ Year: \_\_\_\_\_

How would you rate your experience (please circle):

(not satisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)

Please Explain: \_\_\_\_\_

Have you ever been recommended antibiotic coverage prior to surgery or dental procedures? YES NO

Have you ever had abnormal bruising/bleeding associated with a dental procedure? YES NO

Have you ever had an adverse reaction to dental freezing/local anesthetic?

YES NO

Where would you rate your level of nervousness about dental treatment (please circle):

(not nervous at all)

(very nervous)

1 2 3 4 5 6 7 8 9 10

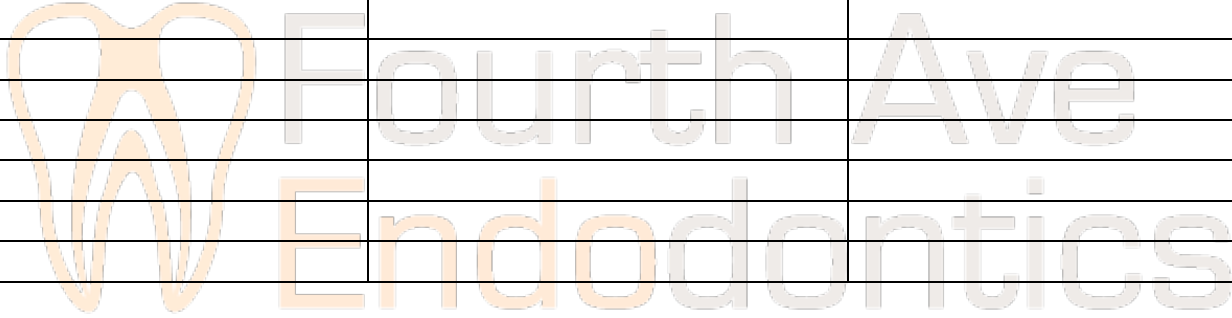
Concerns related to nervousness: \_\_\_\_\_

**Medication List**

Name:

Date:

Medication Name	Dose	Frequency (how often)



If you require assistance in filling out this section, please bring your medication bottles to your appointment or, with your permission, we can call your pharmacy and request a list of current medications.

I understand that the answers to these questions are necessary to provide me with the best possible care and favourable outcome. I have answered all questions truthfully and to the best of my knowledge. I consent to Fourth Ave Endodontics obtaining any other information from other practitioners who are currently or have treated me in the past that will be necessary in providing proper care.

\*I understand that the total payment of dental services is my responsibility, and not that of the insurance company. Payment is due when services are rendered.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_