PATIENT HEALTH HISTORY

Name: _____ Date of Birth (dd/mm/yyyy): _____

Address: _____City: _____Postal Code: _____

Telephone: _____ Cell: _____

Email: _____

Health Card Number:_____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone number: _____

General Dentist: _____

Family Physician: _____ Pharmacy: _____

Do you have insurance coverage? YES NO

Primary Insurance Provider:_____ Policy#_____ ID#:_____

Secondary Insurance Provider:_____ Policy#_____ ID#:_____

Secondary Policy Holder Name _____ Policy Holder Birthdate_____

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1. Are you being treated for any medical condition (currently or within the last year)? _____
2. Has there been any change in your general health in the past year? _____
3. Last medical exam: _____
4. Do you have any conditions that may affect your immune system (e.g. leukemia, HIV, lupus)?

_____

5. Are you undergoing any therapies that could affect your immune system (e.g. radiotherapy, chemotherapy)? _____

6. Are you currently taking any steroids or cortisone? YES NO
7. Do your ankles, feet or hands swell? YES NO
8. Are you allergic to any medications? YES NO

   If so, which medications? _____

9. Are you allergic to latex? YES NO

   Are you allergic to rubbers? YES NO

   Are you allergic to any metals? YES NO

10. Are you allergic to any food? _____

11. Do you have any other allergies that we should be aware of? _____

12. Have you ever had any peculiar or adverse reactions to any medications or injections?

_____

13. Are you taking or have you ever taken osteoporosis medications (e.g. Fosamax or Actonel)?

_____

14. Are you taking any prescription medications? *If you require assistance in filling out this section, with your permission, we can call your pharmacy and request a list of current medications.*

Medication Name	**Dose**	**Frequency**

15. Have you been advised against taking any medication? _____

16. Are you taking any non-prescription medication? _____

17. Do you take any recreational drugs on a regular basis? _____

18. Are you taking any herbal supplements of any kind? _____

19. Do you have diabetes? _____ Type 1 or 2? _____
Is it controlled by diet or medication? _____

20. Do you have or have you had any of the following?:

	YES/NO		YES/NO		YES/NO
Arthritis/Rheumatism		Asthma		Cancer	
Chest pain/Angina		Crohn's		Drug/Alcohol Dependency	
Fainting/Dizzy spells		Glaucoma		Head/Neck Injury	
Heart Attack		Heart Murmur		Hepatitis A	
Hepatitis B		Hepatitis C		Hyperglycemia	
Hypoglycemia		Jaundice		Kidney Disease	
Liver Disease		Lung Disease		Malignant Hyperthermia	
Mitral Valve Prolapse		Pacemaker		Rheumatic/Scarlet Fever	
Seizures		Shortness of Breath		Sickle Cell Disease	
Sinus Trouble		Stomach Ulcers		Stroke	
Thyroid Disease		Tuberculosis		Herpes	
Psychiatric/Mental disorder		Hay Fever		None of the above	

21. Do you have any conditions or diseases not previously listed that we should be aware of?_____

22. Are there any diseases or medical conditions that run in your family?
    - ☐ Cancer
    - ☐ Diabetes
    - ☐ Heart Disease
    - ☐ None
    - ☐ Other: _____

23. Do you have a bleeding problem or bleeding disorder? YES NO

24. Do you have or have you had a replacement or repair of a heart valve or stent? YES NO

25. Do you have or have you ever had an infection of the heart? YES NO

26. Have you had an organ transplant? YES NO

27. Do you have a heart condition from birth (e.g. congenital heart disease)? YES NO

28. Do you have or have you ever had any blood pressure problems? YES NO

29. Do you have a prosthetic or artificial joint? YES NO

30. Have you ever been hospitalized or an illness/operation with the past 5 years? YES NO
    If so, why? _____

31. Have you ever had an injury to your face or jaw? YES NO

32. Do you smoke or chew tobacco products? YES NO

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

(not at all) 1 2 3 4 5 6 7 8 9 10 (very nervous)

Concerns related to nervousness:

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34. Is there anything else about your health we should be aware of? _____

35. Do you wish to speak to the doctor privately about any problem or medical condition? _____

WOMEN:

Are you Pregnant? YES NO Due Date: _____

Are you Breastfeeding? YES NO

CHILDREN:

Has the child patient recently had any of the following?

- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Strep Throat
- ☐ Tonsilitis
- ☐ None of the above

Are there any immunizations the child is not up to date with? YES NO

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

** 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: _____