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:

Are you Pregnant? YES NO Due Date: _____

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) (very satisfied)

1 2 3 4 5 6 7 8 9 10

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: _____