Ultra Endodontics
SPECIALISTS IN ROOT CANAL THERAPY & MICROSURGERY

Health History Form

Today's Date_____

First Name _____ M.I._____ Last Name_____

Date of Birth _____/_____/_____ Gender: Male / Female Height:_____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe why you are here today:

_____

Date of your last dental exam and what was done at that time:

_____

Have you been hospitalized or had a serious illness in the past 5 years? Yes No
why_____

Have you had a hard time getting numb for dental work in the past? Yes No

Are you currently under a physician's care for a particular problem? Yes No

If yes, what?_____

What is your Pharmacy? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had: **Please Circle All That Applies**

Heart Disease (please circle): heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes	No	Lung disease (please circle): asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, shortness of breath?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body: heart valve, pacemaker, hip, knee?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease: jaundice, hepatitis A, B, or C ?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Neck lump/swelling, facial or jaw pain	Yes	No	Headache or migraine	Yes	No
Any chemotherapy, transplant operation, or cancer? If so, what kind and last treatment date?_____	Yes	No	Do you have any other disease, condition, or problem not listed above? If yes, explain _____	Yes	No

FAMILY MEDICAL HISTORY

Do you have any significant family history of disease? Yes No If yes, explain _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No Current Trimester? 1st 2nd 3rd

Expected delivery date? _____ Are you nursing? Yes No

Are you taking birth control pills? _____

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Health History Form

MEDICATIONS

Does your physician recommend you take antibiotics prior to all dental treatment? (heart condition, joint replacement, or a history of infective endocarditis) Yes No

If yes, list antibiotic medication and dose:

_____

Have you ever taken bone modifying drugs ? (i.e. Prolia, Zometa or Fosamax) Yes No

If yes, list drugs used and time of use:

_____

Please list any medications you are currently taking including prescription medications, over the counter medications and vitamins.

Medication	Dosage/Frequency	Reason for Taking	**Medication**	Dosage/Frequency	Reason for Taking

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Medications? Yes No

If so, please list:_____

_____

Have you or an immediate family member had any problems associated with local anesthesia, general anesthesia and/or intravenous sedation? Yes No If yes, which _____

Allergies to food products? Yes No

If so, please list:

_____

_____

Allergy to latex? Yes No

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Do currently use:

Alcohol? Yes No

Tobacco? Yes No

Recreational drugs? Yes No

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain_____

Do you have any dental anxieties or fears? Claustrophobia? Yes No If Yes, please explain_____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

Revised: January 2023