Contemporary Endodontics of Coral Springs

HEALTH HISTORY

	Yes	No
1) Are you in good health?	☐	☐
2) Have you been treated by a physician during the past five years?	☐	☐
If so, please give reason. _____		
3) Are you taking any medications now?	☐	☐
If so, please give reason. _____		

4) Are you sensitive or allergic to: ☐ penicillin ☐ anesthetic ☐ latex ☐ codeine
any other medications? _____

	Yes	No
5) Have you ever had an unfavorable reaction following dental treatment?	☐	☐
If so, please give reason. _____		
6) Have you ever had excessive bleeding requiring special treatment?	☐	☐
7) Have you ever had any of the following illnesses?	☐	☐

☐ stroke ☐ heart trouble ☐ high blood pressure ☐ tumors
☐ asthma ☐ tuberculosis ☐ rheumatic fever ☐ diabetes
☐ hepatitis ☐ stomach problems ☐ kidney disease ☐ epilepsy

8) Have you ever had any other serious illness?	☐	☐
9) Female patients: Are you pregnant?	☐	☐
10) Is there any other information that should be known about your health? _____		
11) Have you ever been infected with Hepatitis or HIV?	☐	☐
If so, please specify. _____		

Patient or Guardian Signature

Date