TREASURE VALLEY
ENDODONTICS

HEALTH HISTORY

Medical Physician's Name: _____ Phone: (_____) _____ - _____

Do you now or have you ever had any of the following (circle all that apply):

A. **Cardiovascular System**:
1. Infective endocarditis. . . . . YES NO
2. Congenital heart disease (heart murmur). YES NO
3. Prosthetic heart valve. . . . . YES NO
4. High or low blood pressure. . . . . YES NO
5. Heart attack, disease, or surgery . . . . . YES NO
6. Chest pain (angina). . . . . YES NO
7. Stroke. . . . . YES NO

B. **Nervous System:**
1. Epilepsy, seizures, or fainting. . . . . YES NO
2. Neuritis, neuralgia, or numbness. . . . . YES NO
3. Psychological disorders, depression. . . . . YES NO

C. **Respiratory System**:
1. Tuberculosis. . . . . YES NO
2. Pneumonia, asthma, emphysema, COPD. YES NO
3. Sinus trouble, hay fever, allergies. . . . . YES NO
4. Tobacco use (including smokeless). . . . . YES NO

D. **Genitourinary and Gastrointestinal Systems:**
1. Kidney disease. . . . . YES NO
2. Liver disease, jaundice, or hepatitis. . . . . YES NO
3. Stomach or intestinal problems. . . . . YES NO
4. Ulcers, reflux disease. . . . . YES NO
5. Eating disorders. . . . . YES NO

E. **Endocrine System**:
1. Diabetes. . . . . YES NO
2. Thyroid disease. . . . . YES NO

F. **Musculoskeletal System (Bones & Joints):**
1. Arthritis (osteo or rheumatoid). . . . . YES NO
2. Joint replacement. . . . . YES NO
3. Back, neck, or jaw injury. . . . . YES NO

G. **Hematologic System (Blood & Lymphatics)**:
1. Blood disorder or anemia. . . . . YES NO
2. Abnormal bleeding or bruising . . . . . YES NO

H. **Infectious Disease**:
1. Hepatitis (B C Other). . . . . YES NO
2. Sexually transmitted diseases . . . . . YES NO

I. **Allergic (swelling, rash) & Adverse Reactions:**
1. Latex. . . . . YES NO
2. Penicillin. . . . . YES NO
3. Other antibiotic: _____. . . . YES NO
4. Aspirin. . . . . YES NO
5. Local anesthetic: _____. . . . YES NO
6. Other: _____. . . . YES NO

J. **Miscellaneous**:
1. Have you ever taken bisphosphonates?. . YES NO
2. Have you ever taken steroids?. . . . . YES NO
3. Have you ever had radiation therapy?. . . . YES NO
4. Alcohol or drug use. . . . . YES NO
5. Cancer. . . . . YES NO
6. Blood transfusion. . . . . YES NO
7. Disorders of sensory organs . . . . . YES NO
8. Significant oral and/or facial pain. . . . . YES NO
9. Oral sores. . . . . YES NO
10. Immunosuppressive condition. . . . . YES NO
11. Hospitalization in the past 5 years. . . . . YES NO

K. **For Women Only**:
1. Is there a chance you could be pregnant? YES NO
2. Are you nursing an infant?. . . . . YES NO

Medications: Please list all substances (including supplements and OTC or prescription medications) you take or should be taking:

Drug Name	Dose	How Often?	Reason for Taking

If unable to list all medications above, please request and complete a Supplemental Medication List from our receptionist

My signature certifies that the health information I have provided is complete and accurate. I agree to inform Stanton D. Widmer, D.D.S. of any changes in my medications or health prior to any future treatment.

_____ _____

Signature of patient, parent, or guardian Date

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