OREGON ENDODONTIC GROUP
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Practice Limited to Endodontics
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Patient Name:

Patient DOB:

Health History

These questions are *confidential* and help us provide better care.

Name of your referring dentist:_____Last visit:_____
Why have you come to see us today?_____
Are you nervous about seeing a dentist? ☐Yes! ☐No If yes please tell us why:_____

		YES	NO
1.	Are you in good health?……..	☐	☐
2.	Have you seen a physician in the last 2 years?……..	☐	☐
3.	Do you have any allergies?…….	☐	☐
	*If yes, please list*_____		
4.	Have you had an unfavorable reaction to dental treatment?…….	☐	☐
	*If yes, please specify*_____		
5.	Have you ever had excessive bleeding requiring special treatment?…… …….	☐	☐
6.	Have you had any other serious illness?…… ……..	☐	☐
	*If yes, please list*_____		
7.	If female, are you or might you be pregnant? Which month?……	☐	☐
	Are you nursing?……	☐	☐
8.	Are you in a high risk group for infectious diseases?……	☐	☐

9. Please indicate any of the following illnesses you have had:

☐Anemia	☐Hay Fever	☐Ulcers or Colitis	☐Head Injuries
☐Asthma	☐Heart Murmur/Mitral Valve Prolapse	☐Stomach Problems	☐Sinus Problems
☐Blood Condition/Disease	☐Hepatitis (Type___)	☐Respiratory Problems	☐Hearing Loss
☐Cancer (Type_____)	☐Rheumatic Fever	☐Lung Disease	☐Stroke
☐Chemotherapy	☐Tumors/Malignancy	☐Pacemaker	☐Liver Disease
☐Radiation Treatment	☐Infectious Mononucleosis(“Mono”)	☐Nervous/Emotional Disorders	☐Diabetes
☐Jaundice	☐Prolonged Bleeding Disorder	☐Arthritis	☐Seizures
☐Dizziness	☐Kidney Condition/Disease	☐History of drug addiction	☐Fainting
☐Excessive Urination and/or Thirst	☐Sexually Transmitted/Venereal Diseases	☐Congenital Heart Defects	☐Epilepsy
☐Glaucoma	☐Herpes	☐Stent	☐Mental Disorders
☐Low Blood Pressure	☐HIV	☐Heart Condition/Disease	☐Tuberculosis
☐High Blood Pressure	☐AIDS		

☐I have Consumed Alcohol in the last 24 hours
☐I usually take an antibiotic before dental treatment
☐Have you ever taken Fen-Phen or Redux?
☐I smoke or use chewing tobacco. If yes, how much per day?_____How many years?_____
☐Major surgeries: Yr._____ Type of operation_____ Yr._____ Type of operation_____
☐Artificial Joints/Implants Hip-Knee_____ Other:_____
☐Other _____

10. Are you taking any of the following?

☐Antibiotics/Sulfa Drugs	☐Anticoagulants (Blood Thinners)	☐Nitroglycerin
☐Meds for High Blood Pressure	☐Cortisone (Steroids)	☐Tranquilizers
☐Insulin, Tolbutamide or similar drug	☐Aspirin	☐Digitalis or drugs for heart
☐Bisphosphonates (such as Fosamax,Boniva, Actonel, Aredia, Zometa, ect.)		☐Plavix

11. Please List all of the medications you are taking(*if you have a list you would like to give to us please give to receptionist*):

Medication:_____Condition: _____
Medication:_____Condition: _____
Medication:_____Condition: _____
Medication:_____Condition: _____
Physicians Name:_____Phone:_____

12. Are you allergic to any of the following?

Please circle Y for yes and N for no

Y N Aspirin	Y N Sulfa Drugs/Sulfates/Sulfides
Y N Ibuprofen	Y N Latex, Metals, Plastics
Y N Penicillin	Y N Local Anesthetics(i.e., Novocaine, Lidocaine)
Y N Codeine	Y N Other medications_____

Consent

I will answer all health questions to the best of my knowledge. This includes any medical history and insurance information. I understand that it is my responsibility to inform the office of any change in my medical and insurance history status.
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Patient’s Signature (If minor Parent or Guardian’s Signature) Date Assistant

Doctor’s Signature Date