Michigan Endodontics, P.C.
Blue Water Endodontics

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PATIENT NAME (Last, First, Middle Initial): _____

Date of Birth: _____

HEALTH HISTORY FORM

Please mark the appropriate response below: Yes (Y), No (N), I Don't Know (?)

Do you have or have you had any of the following?

1. Breathing problems? **Y** **N** **?**
- a. Asthma ☐ ☐ ☐
- b. COPD/ Emphysema ☐ ☐ ☐
- c. Bronchitis ☐ ☐ ☐
- d. Tuberculosis ☐ ☐ ☐
- e. Other breathing problems:
  Explain:_____

2. Heart or circulation problems? **Y** **N** **?**
- a. High blood pressure ☐ ☐ ☐
- b. Heart attack ☐ ☐ ☐
  Date of heart attack: _____
  Stents (Number, date): _____
  Bypass (Number, date): _____
- c. Angina or chest pain ☐ ☐ ☐
- d. Irregular heartbeat ☐ ☐ ☐
- e. Atrial fibrillation ☐ ☐ ☐
- f. Heart murmur ☐ ☐ ☐
- g. Mitral valve prolapse ☐ ☐ ☐
- h. Heart valve replacement ☐ ☐ ☐
  Date: _____
- i. Pacemaker or other cardiac devices ☐ ☐ ☐
- j. Congestive heart failure ☐ ☐ ☐
- k. Other heart or circulation problems:
  Explain:_____

3. Kidney or urinary problems? **Y** **N** **?**
- a. Kidney disease ☐ ☐ ☐
- b. Dialysis ☐ ☐ ☐
- c. Other kidney problems:
  Explain: _____

4. Nervous system problems? **Y** **N** **?**
- a. Stroke or transitory ischemic attack ☐ ☐ ☐
  Date: _____
  Residual deficits: _____
- b. Seizures/epilepsy ☐ ☐ ☐
- c. Other nervous system problems:
  Explain:_____

5. Cancer history? **Y** **N** **?**
  Site: _____
  Date: _____
  Surgery ☐ ☐ ☐
  Chemotherapy ☐ ☐ ☐
  Radiation ☐ ☐ ☐

6. Hormone or gland problems? **Y** **N** **?**
- a. Thyroid disease ☐ ☐ ☐
- b. Diabetes ☐ ☐ ☐
- c. Pancreatic disease ☐ ☐ ☐
- d. Other hormone/gland problems
  Explain: _____

7. Stomach, liver, or intestinal problems **Y** **N** **?**
- a. Liver Disease ☐ ☐ ☐
- b. Hepatitis ☐ ☐ ☐
- c. Acid reflux (GERD) ☐ ☐ ☐
- d. Ulcers ☐ ☐ ☐
- e. Irritable Bowel Syndrome(IBS) ☐ ☐ ☐
- f. Ulcerative Colitis or Crohn's Disease ☐ ☐ ☐
- g. Other stomach, intestinal, or liver problems
  Explain: _____

8. Autoimmune system problems? **Y** **N** **?**
- a. Lupus ☐ ☐ ☐
- b. Rheumatoid Arthritis ☐ ☐ ☐
- c. Organ or bone marrow transplant ☐ ☐ ☐
- d. Sarcoidosis ☐ ☐ ☐
- e. Other autoimmune problems
  1. Explain:_____

9. Orthopedic problems? **Y** **N** **?**
- a. Joint replacement (hip, knee, shoulder, etc) ☐ ☐ ☐
  Location: _____
  Date: _____
- b. Back/neck problems ☐ ☐ ☐
  Explain: _____

10. Bleeding problems? **Y** **N** **?**
- a. Are you taking blood thinners? ☐ ☐ ☐
  Medication/Amount: _____
- b. Are you taking aspirin? ☐ ☐ ☐
  Medication/Amount: _____

11. Mental health problems? **Y** **N** **?**
- a. Anxiety ☐ ☐ ☐
- b. Other mental health problems
  Explain:_____

	Y	N	?
12. Does your physician recommend you take Antibiotics before dental treatment?	☐	☐	☐

a. If yes, reason: _____
b. If yes, medication and dosage your physician recommends: _____

13. Have you ever taken or are you taking drugs to control bone loss (eg osteoporosis), either IV or oral (ie Fosamax, Boniva, Prolia)?	☐	☐	☐

14. What medications or other substances are you taking or have you taken in the past two months?
    a. Please list all prescription and non-prescription medications:

_____
_____
_____

	Y	N	?
15. Do you have a **LATEX** allergy?	☐	☐	☐

	Y	N	?
16. Are you allergic to any medications?	☐	☐	☐

a. Please list all medications you are allergic to:

_____
_____

17. **Personal History**

	Y	N	?
a. Have you ever been hospitalized, seriously injured, or had major surgery?	☐	☐	☐
i. If yes, explain what/when: _____			
b. Do you need any special accommodations for dental treatment?	☐	☐	☐
1. If yes, explain: _____			
c. Are you pregnant?	☐	☐	☐
1. If yes, due date? _____			
2. Are you breastfeeding? _____			
d. Have you ever experienced/been treated for Temporomandibular Joint problems (TMD)?	☐	☐	☐
1. Do you have a bite splint?	☐	☐	☐
e. Are you currently under the care of a physician?	☐	☐	☐
1. If yes, name of physician: _____			
1. Phone number of physician's office? _____			

18. Please describe any additional medical concerns not listed above:

_____
_____
_____