



1931 Farmerville Hwy

Ruston, LA 71270

318.255. ENDO (3636)

Health History

Patient Name _____ Date _____

Do you have, or have you had any of the following conditions? Please Circle (Y) Yes or (N) No.

Cardiovascular Disease

- High Blood Pressure
- Low Blood Pressure
- Y N Arteriosclerosis
- Y N Heart Attack. If YES, when _____
- Y N Heart By-Pass Surgery. If yes, when _____
- Y N Prosthetic Heart Valves
- Y N Congenital Heart Malformations
- Y N Hypertrophic Cardiomyopathy
- Y N Mitral Valve Prolapse
- Y N Heart Murmur
- Y N Rheumatic Fever
- Y N Bacterial Endocarditis
- Y N Other. Please explain. _____

Other Medical Conditions

- Y N Diabetes.
- If YES, are you taking insulin? Y N
- Y N Blood transfusion since 1980?
- Y N Hepatitis: A ____ B ____ C ____
- Y N Liver Disease
- Y N Stomach Ulcers
- Y N Kidney Problems
- Y N Arthritis or Rheumatism
- Y N Tuberculosis
- Y N Venereal Disease
- Y N HIV or AIDS
- Y N Epilepsy
- Y N Abnormal bleeding
- Y N Anemia
- Y N Cancer. If YES, are you currently on
Chemotherapy or radiation? Y N

- Y N Osteoporosis
- Y N Sinus Problems / Seasonal Allergies
- Y N Asthma
- Y N Cocaine Use
- Y N Have you ever been treated for drug addiction?
- Y N Do you require antibiotics prior to dental treatments?
- Y N Other. Please explain _____

ALLERGIES

- Y N Penicillin / Antibiotics
- Y N Sulfa Drugs
- Y N Codeine
- Y N Iodine
- Y N Aspirin
- Y N Latex
- Y N Local Anesthetics
- Y N Other _____

Are you currently under a physician's care? Y N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____

Are you currently taking any medications, pills, or drugs? Y N If yes, please explain: _____

For women only: Are you pregnant or trying to get pregnant? Y N

Are you nursing? Y N

Are you taking oral contraceptives? Y N

Have you had any serious illness or condition not mentioned above? Y N If Yes, please explain: _____

Is this dental visit related to an accident? Y N Was the accident work related? Y N Please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ DATE _____