HARPETH
—ENDODONTICS—

Health History Form

Patient Name:_____ DOB:_____/_____/_____
First *Last* *Middle Initial*
Reason for Today's Visit:_____
Referring Dentist:_____Date of last dental exam:_____/_____/_____
Physician's Name:_____Date of Last Visit:_____/_____/_____
Emergency Contact:_____Phone:_____
Have you had any serious illnesses or operations? [ ] Yes [ ] No
If yes, describe:_____

Check if you have problems with any of the following:

[ ] Sensitivity to cold
[ ] Sensitivity to hot
[ ] Sensitivity to biting
[ ] Sensitivity to sweets
[ ] Swelling
[ ] Sores or gum pimple
[ ] Grinding Teeth
[ ] Loose teeth
[ ] Broken fillings

Check if you have or have had any of the following:

[ ] Alcoholism
[ ] Anemia
[ ] Arthritis/Rheumatism
[ ] Artificial Joint(s)
_____
(date of surgery)
_____/_____/_____
[ ] Asthma
[ ] Back Pain/Problems
[ ] Bleeding Disorder
[ ] Blood Transfusion
[ ] Cancer
_____
(type)
[ ] Chemotherapy
[ ] Circulatory Problems
[ ] Cold Sores/Herpes
[ ] Congenital Heart Defect
[ ] Diabetes
[ ] Drug Addition
[ ] Endocarditis
[ ] Epilepsy
[ ] Fainting/Dizzy Spells
[ ] Glaucoma
[ ] Hay Fever
[ ] Hemophilia
[ ] Heart Murmur
[ ] Heart Problems
[ ] Heart Valve Replacement
(date of surgery)
_____/_____/_____
[ ] Hepatitis (type:_____)
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney Disease
[ ] Liver Disease
[ ] Pacemaker
[ ] Parkinson's
[ ] Psychiatric Treatment
[ ] Radiation Treatment
[ ] Respiratory Disease
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Shingles (currently)
[ ] Sickle Cell Disease
[ ] Steroid Treatment
[ ] Stroke
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Other

If yes to any of the above please elaborate:_____

Women Only:

Are you Pregnant? [ ] Yes [ ] No If Yes, how many weeks? _____
Are you nursing? [ ] Yes [ ] No

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Medications/Vitamins You Take:

_____
_____
_____
_____
_____
_____
_____

Allergies You Have:

_____
_____
_____
_____
_____
_____
_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I/the patient have/has a change in health history.

Printed Name Of Patient/Guardian:_____
Relationship to Patient:_____

Signature Of Patient/Guardian:_____
Date:_____/_____/_____