HEALTH HISTORY

PLEASE CHECK THE BOX BESIDE ANY OF THE DISEASES OR CONDITIONS YOU HAVE.

- o ALCOHOL/DRUG ABUSE
- o ANGINA
- o ARTHRITIS
- o ARTIFICIAL JOINTS
- o ASTHMA
- o BLEEDING DISORDERS
- o CARDIOVASCULAR DISEASE
- o DIABETES
- o DIGESTIVE DISORDERS
- o DRUG ALLERGIES
- o EPILEPSY/SEIZURES
- o FEVER BLISTERS
- o HEART ATTACK
- o HEART MURMUR
- o HERPES
- o HIGH BLOOD PRESSURE
- o HIV/AIDS
- o HORMONAL PROBLEMS
- o HYPOGLYCEMIA
- o KIDNEY PROBLEMS
- o LATEX ALLERGY
- o LOW BLOOD PRESSURE
- o MITRAL VALVE PROLAPSE
- o PREGNANCY
- o RESPIRATORY DISEASE
- o RHEUMATIC FEVER
- o RHEUMATIC HEART DISEASE
- o SHORTNESS OF BREATH
- o SINUS PROBLEMS
- o STROKE
- o THYROID PROBLEMS
- o TUBERCULOSIS
- o ULCERS
- o VENEREAL DISEASE

DO YOU PREMED PRIOR TO DENTAL TREATMENT DUE TO ARTIFICIAL JOINTS/HEART CONDITIONS/ETC?
YES NO IF YES, LIST _____

ARE YOU CURRENTLY TAKING AN ANTIBIOTIC? YES NO IF YES, LIST _____

LIST ANY DRUGS YOU ARE ALLERGIC TO OR WRITE "NONE" _____

LIST ANY MEDICATIONS YOU ARE TAKING _____

_____

LIST ANY MEDICAL CONDITIONS NOT LISTED ABOVE _____

PHYSICIAN _____ LAST VISIT _____

DENTIST _____ LAST VISIT _____

LIST ANY CONCERNS YOU HAVE REGARDING DENTAL TREATMENT _____

_____

RELEASE OF DENTAL AND PERSONAL INFORMATION

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be release to the following people:

SPOUSE _____

CHILDREN _____

OTHER _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medications, I will inform Dr. Lamb or Dr. Pearson at my next appointment.

I acknowledge I have received a copy of the Southern Endodontic Center Notice of Privacy Practices.

Patient/Guardian Signature _____ Date _____