Grove Endodontics PA • Thomas Waldron, D.D.S. • 8811 92nd Street South, Suite 109 • Cottage Grove, MN 55016 • (651) 768-8180

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now?
   If YES, explain _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
6. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Fainting spells	Diarrhea or constipation
Jaundice	Dry mouth	Difficulty swallowing
Headaches	Swollen ankles	Dizziness
Jaw joint pain or stiffness	Bleeding problems	Blurred vision
Shortness of breath	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Surgeries	Osteoporosis	Heart attack
Hospitalization	Thyroid disease	Artificial joint
Diabetes	Asthma	Stomach problems or ulcers
Hepatitis	Heart defects	Tumors or cancer
Sexual transmitted disease	Heart murmurs	Chemotherapy
Herpes	Rheumatic fever	Radiation
Arthritis, rheumatism	Blood disorders	Emphysema or other lung disease
Liver disease	High blood pressure	Kidney or bladder disease
Eye disease	Seizures	Stroke
Transplants	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Valium	Vicodin	Codeine
Penicillin	Local anesthetic	Latex
Nitrous oxide	Food	Metal

Others: _____

OVER ⇨

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs | Antibiotics | Over-the-counter medicines
Supplements | Bisphosphonate (Fosamax) | Aspirin

Please list all medications you are currently taking: _____

_____

_____

_____

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, what month? _____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes No Have you ever been pre-medicated for dental treatment?
If YES, why _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian): _____ Date: _____

Signature of Dentist: _____ Date: _____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____