Deborah Ann Conner, DDS, PLLC

practice limited to endodontics

Confidential Health History

Patient Name: ____

✓ Check/circle any of the following you have or have ever had:

_____ Anemia
_____ Angina
_____ Asthma, sleep apnea, COPD
_____ Blood disorders/transfusions, Prolonged bleeding
_____ Cancer or tumor
_____ Dental anxiety
_____ Diabetes
_____ Epilepsy
_____ Fever blister, cold sore, herpes virus
_____ Gag reflex
_____ Heart disease or heart attack
_____Hepatitis, Liver disease
_____ High or low blood pressure
_____ Human immunosuppressant virus/Antibodies
______ Hypo/Hyperthyroid
______ Joint/heart valve replacement
______ Pacemaker
______ Psychiatric treatment
______ Radiation (X-ray) therapy
______ Rheumatic fever
______ Severe infections
______ Stroke
______ Surgery
______ TMJ/TMD
______ Tuberculosis
______ Ulcers
____
____

Are you presently under a physician's care: Yes _________ No ________

If yes, reason: ____

If yes, Medical Doctor's name: ______________________Phone: ____________

Do you require antibiotic or sedative pre-medication? ______ Why? ______________

Are you hard to get numb? _____ Any other issues?______________________

List all medications you are presently taking:

Medication	Action

Pharmacy: ______________________________ Phone: ________________

Are you allergic or suffer ill-effects from the following?

______ Penicillin ________ Sulfa _______ Aspirin ______ Codeine __________ Latex

______ Shellfish ________ Iodine Others ______________________________

Women only: Are you pregnant? __________ If so, what month? ________________

Are you taking any hormonal or birth control medication? Yes _________ No ________

I affirm the above information is accurate to the best of my knowledge.

Signature ___________________________________ Date ______________

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