# Deborah Ann Conner, DDS, PLLC

*practice limited to endodontics*

## Confidential Health History

Name: _____ Referring Doctor: _____

✓ 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 or Afib
_____ Heart valve replacement
_____Hepatitis, Liver disease
_____ High or low blood pressure
_____ Human immunosuppressant virus/Antibodies

_____ Hypo/Hyperthyroid
_____ Joint replacement
_____ Pacemaker
_____ Panic Attacks
_____ Psychiatric treatment
_____ Radiation (X-ray) therapy
_____ Rheumatic fever
_____ Severe infections
_____ Stroke
_____ Surgery
_____ TMJ/TMD
_____ Tuberculosis
_____ Ulcers
Other:_____
_____

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 your medications (including those taken on an as-needed basis)

| Medication | Action |
|---|---|
| | |
| | |
| | |
| | |

Pharmacy: _____ Phone: _____

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

_____ Penicillin _____ Sulfa _____ Aspirin _____ Codeine _____ Latex

_____ Shellfish _____ Iodine Others _____

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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