



West Seattle Endodontics

5016 California Ave. SW Seattle, WA 98136 206-937-1010

Health Questionnaire

Physician: _____ Phone Number: (____) _____ - _____

Date of Last Physical Exam: _____

In case of Emergency, please call:

Name: _____ Phone: (____) _____ - _____ Relationship: _____

Please check any of the following that apply to you now or in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Sinusitis/ Hay Fever |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Dizzy Spells/Fainting |
| <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Jaw Joint pain (TMJD) |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Phen-Fen use | <input type="checkbox"/> Smoking/Tobacco use |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Allergies/Hives |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Back/Neck pain |

Have you ever had an allergy or reaction to any of the following:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Any Antibiotics | <input type="checkbox"/> Local Anesthetics or Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Any Medications | <input type="checkbox"/> Other _____ |

Any other disease or serious illness?: _____

Current Medications (including vitamins/herbs)? _____

Women – Are you: Pregnant Nursing Taking Birth Control Pills

Signature: _____ Date: _____

Notes: _____