ESV
ENDODONTICS
OF SILICON VALLEY

PATIENT HISTORY & INFORMATION (please print neatly)

Name: _____ Sex: M F Marital Status: _____ Birthdate: _____
(first) (middle initial) (last)

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Home Ph #: _____ Cell Ph #: _____

Occupation: _____ Employer: _____

Employer/School Address: _____ City: _____ State: _____ Zip: _____

Name of Emergency Contact: _____ Home Ph #: _____ Cell Ph #: _____

Who is your general dentist? _____

SPOUSE / PARENT INFORMATION

Name: _____ Relationship: _____ Birthdate: _____
(first) (middle initial) (last)

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Home Ph #: _____ Cell Ph #: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

1. Is your general health good? ..... Yes No
   If NO, please explain: _____
   _____
2. What medications are you currently taking (including herbs, vitamins and diet pills)
   _____
   _____
3. Have you ever taken the diet drug Phen-Phen (also known as Redux or Pondimen)? ..... Yes No
4. Have you ever taken a drug known as a bisphosphonate used to treat osteoporosis and some cancers?
   (Examples include Fosamax, Actonel, Boniva, Zoneta, Bonefos, Aredia) ..... Yes No
5. Do you have any allergies to or are you sensitive to latex? ..... Yes No
6. **Do you have any allergies to or are you sensitive to any drugs such as penicillin?** ..... Yes No
   If YES, please list them here: _____
   _____
7. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy? ..... Yes No
8. Have you ever had any of the following (check all that apply):
   - ☐ Asthma
   - ☐ Pneumonia
   - ☐ Emphysema
   - ☐ Tuberculosis
   - ☐ Chronic Cough
   - ☐ Any other lung disorders – please indicate: _____
9. Do you have a ***heart issue*** and your **PHYSICIAN** or **CARDIOLOGIST** advised you to take antibiotics prior to all dental treatment, including routine dental cleanings? ..... Yes No
10. Have you ever experienced any of the following (check all that apply):
    - ☐ AIDS or HIV
    - ☐ Alcohol / Drug Abuse
    - ☐ Anemia
    - ☐ Bleeding Problems
    - ☐ Bruise Easily
    - ☐ Cancer – Date _____
    - ☐ Chest Pains (angina) / Shortness of Breath
    - ☐ Diabetes – what type ____
    - ☐ Hepatitis – what type ____
    - ☐ Heart Problems
    - ☐ Cholesterol
    - ☐ High or Low Blood Pressure
    - ☐ Kidney Disease
    - ☐ Prosthetic Heart Valve / Prosthetic Joint (i.e. artificial hip) – premedication required? ..... Yes No
    - ☐ Radiation Therapy / Chemotherapy .....
    - ☐ Rheumatic Fever / Heart Defect / Heart Murmur – premedication required? ..... Yes No
    - ☐ Sinus Problems
    - ☐ Stroke – Date _____
    - ☐ Surgeries / Hospitalization
    - ☐ Thyroid
11. Do you have a condition or problem not listed above that you feel we should know about? ..... Yes No
    If YES, briefly explain: _____
    _____

WOMEN ONLY:

12. Are you or could you be pregnant? Which month: _____ Due Date: _____ ..... Yes No
13. Are you breastfeeding? ..... Yes No
14. Are you taking birth control? ..... Yes No

My signature below indicates I have received a copy of this office's Notice of Privacy Practices

Signature: _____ Date: _____

UPDATE:

Signature: _____ Date: _____