BAY ENDODONTICS
Root Canal Specialists

2844 Summit Street, Suite 209
Oakland, CA 94609
Phone: (510) 451-3636
Email: info@bayrootcanal.com

Phuong N. Quang, D.D.S., Ph.D.
Yvonne Chiu, D.D.S., M.S.

Confidential Health History Form Date: _____

Patient Name: *First*_____ *MI*_____ *Last*_____ **Date of Birth:**_____

1. Are you having tooth pain or discomfort now? ..... Yes No
2. Have you been under the care of a medical doctor during the past two years? ..... Yes No
3. If you have been under the care of a doctor, what condition(s) was treated or is currently being treated?

   _____

   Physician's Name & Number: _____
4. Are you now taking any medications or drugs? ..... Yes No

   If yes, what medications or drugs are you taking?

   _____
5. Are you taking or have you ever taken Fosamax or other medications for bone conditions? ..... Yes No

   If yes, what are the medications or drugs?

   _____
6. Are you sensitive or allergic to any medications or drugs? ..... Yes No

   If yes, what medications or drugs?

   _____
7. Have you ever had any history of TMJ (jaw joint) disorders or pain? ..... Yes No
8. Have you had any adverse reactions during prior dental treatment? ..... Yes No
9. Have you had any surgeries or been hospitalized in the past? ..... Yes No

   If yes, please describe:

   _____

   _____

Please check the box in front of any conditions you have had or presently have:

☐	Heart Failure	☐	Artificial Joint (hip, knee)	☐	Cancer
☐	Heart Disease or Defects	☐	Diabetes	☐	Chemotherapy
☐	Angina / Chest Pain	☐	Tuberculosis	☐	Radiation Therapy
☐	Congenital Heart Disease	☐	Asthma	☐	Osteoporosis
☐	Heart Murmur	☐	Emphysema	☐	Ulcers / Stomach Problems
☐	High Blood Pressure	☐	Chronic Cough	☐	Eye Disease
☐	Hardening of arteries	☐	Liver Disease	☐	Depression
☐	Mitral Valve Prolapse	☐	Hepatitis A or B	☐	Anxiety
☐	Artificial Heart Valve	☐	Hemophilia	☐	Sinus Problems
☐	Pacemaker	☐	Anemia	☐	Cold Sores / Fever Blisters
☐	Heart Surgery	☐	Thyroid Disease	☐	Recreational drugs
☐	Rheumatic Fever	☐	Arthritis / Rheumatism	☐	Cortico-steriods
☐	Stroke	☐	Kidney Problems	☐	Allergies or Hives
☐	STDs	☐	Epilepsy or Seizures	☐	Allergic to Latex
☐	AIDS/HIV	☐	High Cholesterol	☐	Other- specify:

For Women Only

10. Are you pregnant? ..... Yes No For how many months? _____
11. Are you nursing? ..... Yes No
12. Are you taking birth control pills? ..... Yes No

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

Recall updates: Any changes in your medical history since the last time we saw you? ..... Yes No

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____