Central Carolina
ENDODONTICS, P.A.
JOSEPH D. BONAVILLA, D.D.S.
PRACTICE LIMITED TO ENDODONTICS

HEALTH HISTORY

Have you ever had any of the following diseases or medical problems?
(Please read thoroughly and circle "Yes" or "No".)

Yes No Heart Attack/Stroke
Yes No Heart Murmur/Rheumatic Fever
Yes No Heart Surgery/Pacemaker
Yes No Heart Valve (Artificial)
Yes No Chronic Hepatitis
Yes No Anemia
Yes No High/Low Blood Pressure
Yes No Severe Headaches
Yes No Epilepsy/Seizures/Fainting Spells
Yes No Drug/Alcohol Abuse
Yes No Hemophilia/Abnormal Bleeding
Yes No Root Canal Treatment
Yes No Blood Transfusion

Yes No Cancer/Chemotherapy
Yes No HIV+/AIDS
Yes No Shingles
Yes No Kidney Problems
Yes No Sinus Problems
Yes No Fever Blisters
Yes No Psychiatric Care
Yes No Diabetes
Yes No Tuberculosis (TB)
Yes No Sickle Cell Disease
Yes No Joint Prosthesis (Hips, Other)
For Women: Are you pregnant?
If yes, Week# ____

Have you ever experienced any serious medical conditions not listed above?

If yes, please list: ____

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Are you currently under the care of any physician? ◻ **Yes** ◻ No

If yes, please explain: ____

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Are you presently taking any drugs prescribed by a physician or dentist? ◻ **Yes** ◻ No

If yes, please list: ____

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Have you ever taken Bisphosphonates? ◻ **Yes** ◻ No If yes, please circle which one.
(Fosamax, Fosamax Plus D, Zometa, Didronel, Reclast, Boniva, Actonel, Aclasta, Aredia, Atelvia, Skelid)

Are you allergic to the following drugs?
Yes No Penicillin
Yes No Erythromycin
Yes No Dental Anesthetics
Yes No Aspirin
Yes No Tetracycline
Yes No Codeine

Are you allergic to bleach? ◻ **Yes** ◻ No
Are you allergic to **LATEX**? ◻ **Yes** ◻ No
Are you allergic to any other drugs? ◻ **Yes** ◻ No

If yes, please list: ____

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Are you required to take antibiotics prior to dental treatment for artificial joints or heart defects? ◻ **Yes** ◻ **No**
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

WARNING: Birth control pills may be rendered ineffective by antibiotics.

Signature: ______________________________ Date: ____________________