Upper Valley Endodontics

Brooke Blicher, DMD
Rebekah Lucier, DMD

CIRCLE: Ms. Mr. Dr. Other: Date:

Last Name: First Name: Middle: Date of Birth:

Address: Gender:

City: State: Zip Code: Preferred Pronouns:

Email Address: Home Phone:

Occupation: Place of Business Work Phone:

Parent/Spouse/Partner/Child First Name: Cell Phone:

Referring Dentist:

Health History

Physician's Name: Address:

Are you in good health? Yes / No If no, why?

Are you currently under medical care? Yes / No If yes, explain:

Please check if any of the following applies to you:

- ☐ Respiratory disorders *(cough, asthma, shortness of breath, difficulty breathing)*
- ☐ Digestive disorders *(ulcers, ulcerative colitis, Crohn's disease, GERD, etc.)*
- ☐ Infectious Disease *(syphilis, HIV, AIDS, herpes, tuberculosis, hepatitis)*
- ☐ Liver disorders *(hepatitis, jaundice, cirrhosis, fatty liver, etc.)*
- ☐ Cardiac disorders *(heart attack, pacemaker stent, valve replacement, etc.)*
- ☐ Kidney disorder
- ☐ Stroke, TIA, CVA
- ☐ Allergies
- ☐ Diabetes
- ☐ Pregnant or nursing
- ☐ Joint issues *(arthritis, swollen joints, etc.)*
- ☐ Joint replacement surgery
- ☐ Blood disorders *(anemia, platelet disorders, etc.)*
- ☐ Tumor, cancer, cysts, other growths
- ☐ Thyroid disorder
- ☐ Major operation
- ☐ Ear infections or noise
- ☐ Fainting or dizziness
- ☐ High blood pressure
- ☐ Tobacco use
- ☐ Dental anxiety
- ☐ History of bisphosphonate or immunologic drugs
- ☐ Autoimmune disorder
- ☐ Alcohol, Marijuana, or other drug use
- ☐ History of substance use disorder
- ☐ Other: _____

Please explain any positive responses and include other relevant medical information:

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