LA JOLLA ENDODONTICS
Babak Shoushtari, D.M.D.
Practice Limited to Endodontics

HEALTH QUESTIONNAIRE

Patient's Name: _____ Date: _____

Do you have, or have you had, any of the following? Please check.

Yes	No		Yes	No	
☐	☐	Recent Illness (within one year)	☐	☐	Psychiatric treatment
☐	☐	Cough, cold, or flu (w/n 2 months)	☐	☐	Heart Surgery
☐	☐	Shortness of breath	☐	☐	Excessive bleeding
☐	☐	Lung disease	☐	☐	Anemia
☐	☐	Asthma	☐	☐	Treatment of tumor or cancer
☐	☐	Bronchitis	☐	☐	Stroke
☐	☐	Emphysema	☐	☐	Seizures or Epilepsy
☐	☐	Heart Trouble	☐	☐	Exposure to HIV/AIDS
☐	☐	Chest pain	☐	☐	Liver Disease
☐	☐	Heart Attack	☐	☐	Cirrhosis
☐	☐	Irregular Heart beat	☐	☐	Jaundice
☐	☐	Heart murmur	☐	☐	Hepatitis (B or C)
☐	☐	Rheumatic fever	☐	☐	Stomach ulcer
☐	☐	Mitral valve prolapse	☐	☐	Diabetes
☐	☐	High blood pressure	☐	☐	Kidney disease
☐	☐	Artificial joints	☐	☐	Other Serious Illness
☐	☐	Cortisone or ACTH	☐	☐	Taking medications
☐	☐	Bisphosphonate	☐	☐	Allergies/Allergic to medications
☐	☐	Blood vessel grafts	☐	☐	Currently Pregnant
☐	☐	Scarlet fever	☐	☐	Currently taking Birth Control Pills
☐	☐	Arthritis	☐	☐	Currently Breast Feeding

If you answered yes to any of the above please explain:

_____

_____

_____

_____

_____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____