MEDICAL HISTORY

PATIENT NAME		Birth Date	
		uth, your mouth is a part of your entire relationship with the dentistry you will	
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medicati Do you take, or have you taken, P Have you ever taken Fosamax, Bo other medications containing Are yo	nead or neck injury? Yes No ons, pills, or drugs? Yes No rhen-Fen or Redux? Yes No	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
Pregnant/Trying to get pregnant?	Yes No Taking oral contract	eptives? Yes No Nursing	? O Yes O No
Are you allergic to any of the followin Aspirin Penicillin Other If yes, please explain:	g? Codeine Local Anesthet	ics Acrylic Meta	Latex Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive Yes No AIZheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Bruise Easily Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Conyulsions Yes No Have you ever had any serious illne	Cortisone Medicine Yes N Diabetes Yes N Drug Addiction Yes N Easily Winded Yes N Emphysema Yes N Epilepsy or Seizures Yes N Excessive Bleeding Yes N Excessive Thirst Yes N Fainting Spells/Dizziness Yes N Frequent Cough Yes N Frequent Diarrhea Yes N Frequent Headaches Yes N Genital Herpes Yes N Glaucoma Yes N Heart Attack/Failure Yes N Heart Murmur Yes N Heart Pacemaker Yes N Heart Trouble/Disease	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No High Cholesterol Yes No Hypoglycemia Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Liver Disease Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Oparathyroid Disease Yes No Oparathyr	Radiation Treatments Yes No Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Shingles Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Stroke Yes No Stroke Yes No Thyroid Disease Yes No Thyroid Disease Yes No Tuberculosis Yes No Tumors or Growths Yes No Venereal Disease Yes No Yes No Yesllow Jaundice Yes No
Comments:			
		rately answered. I understand that produced dental office of any changes in medic	
SIGNATURE OF PATIENT. PAREN	T or GUARDIAN		DATE