MEDICAL HISTORY

PATIENT NAME		Birth Date	
		outh, your mouth is a part of your entire errelationship with the dentistry you wil	e body. Health problems that you may I receive. Thank you for answering the
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medication Do you take, or have you taken, P Have you ever taken Fosamax, Bo other medications containing Are yo	ead or neck injury? Yes No ons, pills, or drugs? Yes No hen-Fen or Redux? Yes No niva, Actonel or any	o If yes, please explain: o If yes, please explain: o If yes, please explain:	
Do you use con	trolled substances? Yes No		
Women: Are you Pregnant/Trying to get pregnant?	Yes No Taking oral contra	aceptives? Yes No Nursing	g? O Yes No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	g? Codeine Local Anesthe	etics Acrylic Meta	al Latex Sulfa drugs
AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Convulsions Yes No Hoo Convert Pains Yes No Convulsions Yes No Hoo Convulsions Yes No Hoo Convulsions Yes No Hoo Convert Pains Yes No Convulsions Yes No Hoo Convulsions Yes No Convulsions Yes No Hoo Convulsions Yes No Hoo Convulsions Yes No Convulsions Yes	Cortisone Medicine Yes Diabetes Yes Drug Addiction Yes Easily Winded Yes Emphysema Yes Epilepsy or Seizures Yes Excessive Bleeding Yes Excessive Thirst Yes Fainting Spells/Dizziness Yes Frequent Cough Yes Frequent Diarrhea Yes Genital Herpes Yes Glaucoma Yes Heart Attack/Failure Yes Heart Murmur Yes Heart Pacemaker Yes Heart Trouble/Disease Yes Core Easily Winder State Order Trouble/Disease Yes Drug Additional Press Order Trouble/Disease Pres	No Hepatitis A Yes No No Hepatitis B or C Yes No No Herpes Yes No No High Blood Pressure Yes No No High Cholesterol Yes No Hives or Rash Yes No Hives or Rash Yes No No Hives or Rash Yes No No Hives or Pasition Heartbeat Yes No No Hives Disease Yes No No Leukemia Yes No Low Blood Pressure Yes No No Lung Disease Yes No No No Mitral Valve Prolapse Yes No No No Pain in Jaw Joints Yes No No Parathyroid Disease Yes No No No No Parathyroid Disease Yes No	Recent Weight Loss
Comments:			
		curately answered. I understand that prine dental office of any changes in medi	
SIGNATURE OF PATIENT, PAREN	T, or GUARDIAN		DATE