MEDICAL HISTORY

PATIENT NAME		Birth Date	
		outh, your mouth is a part of your entire least on the relationship with the dentistry you will relationship with the dentistry you.	
Have you ever been hospitalized or had Have you ever had a serious I Are you taking any medicati Do you take, or have you taken, F Have you ever taken Fosamax, Bo other medications containin Are yo	nead or neck injury? Yes No ons, pills, or drugs? Yes No Phen-Fen or Redux? Yes No	If yes, please explain:	
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No			
Are you allergic to any of the followin Aspirin Penicillin Other If yes, please explain:	g? Local Anestheti	cs Acrylic Metal	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 Angina Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Arthritical Heart Valve Yes No Arthricial Joint Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Conyulsions Yes No Convulsions Yes No Have you ever had any serious illness	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. Genital Herpes Yes N. Hay Fever Yes N. Heart Attack/Failure Yes N. Heart Murmur Yes N. Heart Pacemaker Yes N.	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Hypoglycemia Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Parathyroid Disease Yes No	Radiation Treatments Yes No Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Scarlet Fever Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stwelling of Limbs Yes No Thyroid Disease Yes No Tonsillitis Yes No Tuberculosis Yes No Tumors or Growths Yes No Yellow Jaundice Yes No
Comments:			
		ately answered. I understand that prodental office of any changes in medica	
SIGNATURE OF PATIENT, PAREN	Γ, or GUARDIAN		DATE