MEDICAL HISTORY

PATIENT NAME		Birth Date	
		outh, your mouth is a part of your entire errelationship with the dentistry you will	
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, Pl Have you ever taken Fosamax, Bo other medications containing Are you	ead or neck injury? Yes No ons, pills, or drugs? Yes No hen-Fen or Redux? Yes No	If yes, please explain: If yes, please explain: If yes, please explain:	
	trolled substances? Yes No		
Pregnant/Trying to get pregnant?		ceptives? Yes No Nursing	g? O Yes O No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	g? Codeine Local Anesthe	tics Acrylic Meta	l 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 Artificial Heart Valve Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Bruise Easily Yes No Cancer Yes No Congenital Heart Disorder Yes No Convulsions Yes No Convulsions Yes No Convulsions Yes No Hoo Asthma Yes No Convulsions Yes Yes No Convulsions Yes Yes No Convulsions Yes No Convulsions Yes Yes No Convulsions Yes Yes No Convulsions Yes No Convulsions Yes Yes Yes No Convulsions Yes No Convulsions Yes Yes Yes No Convulsions Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Yes I Ves I Ve	No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Hives or Rash Yes No Hypoglycemia Yes No Hregular Heartbeat Yes No Kidney Problems Yes No Leukemia Yes No Leukemia Yes No Low Blood Pressure Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No No Steoporosis Yes No Parathyroid Disease Yes No No Parathyroid Disease Yes No No Psychiatric Care Yes No	Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Tonsillitis Yes No Tuberculosis Yes No Ucers Yes No Yes No Ucers Yes No Yes No Yes No Ucers Yes No Yes Yes No Yes Yes Yes No Yes
Comments:			
		urately answered. I understand that pro e dental office of any changes in medic	
SIGNATURE OF PATIENT, PARENT	, or GUARDIAN		DATE