MEDICAL HISTORY

PATIENT NAME		Birth Date	
		uth, your mouth is a part of your entire relationship with the dentistry you will i	
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 you	nead or neck injury? Yes No ons, pills, or drugs? Yes No hen-Fen or Redux? Yes No niva, Actonel or any g bisphosphonates? Yes No o you use tobacco? Yes No trolled substances? Yes No	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain: eptives? Yes No Nursing	? O Yes O No
Are you allergic to any of the following	g?		□ Later □ Sulfa dena
Aspirin Penicillin Other If yes, please explain:	Codeine Local Anesthet	ics Acrylic Metal	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 Breathing Problem Yes No Breathing Problem Yes No Cancer Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Conyulsions Yes No Convulsions 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 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 Kidney Problems Yes No Leukemia Yes No Liver Disease Yes No Mitral Valve Prolapse Yes No Mo Asteoporosis Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No	Radiation Treatments Yes No Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever 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 Stroke Yes No Stroke Yes No Thyroid Disease Yes No Thyroid Disease Yes No Tuberculosis Yes No Tumors or Growths Yes No Ulcers Yes No Yellow Jaundice Yes No Yellow Jaundice Yes No Yes No Yellow Jaundice Yes No Yes No Yes No Tumors or Growths Yes No Yes Yes No Yes Yes No Yes Yes No Yes Yes No Yes Yes No Yes Yes No Yes Yes Yes Yes No Yes
Comments:			
		rately answered. I understand that pro dental office of any changes in medica	
SIGNATURE OF PATIENT, PARENT	or GUARDIAN		DATE