## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
		uth, your mouth is a part of your entire rrelationship with the dentistry you will r	
Have you ever been hospitalized or ha Have you ever had a serious Are you taking any medicat Do you take, or have you taken, I Have you ever taken Fosamax, B other medications containir Are you  Do you use con Women: Are you	head or neck injury? Yes No	If yes, please explain:  If yes, please explain:  If yes, please explain:	
Pregnant/Trying to get pregnant?		ceptives? Yes No Nursing	? O Yes O No
Are you allergic to any of the following Aspirin Penicillin  Other If yes, please explain:	Codeine Local Anesthe	tics Acrylic Metal	Latex Sulfa drugs
AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anathritis/Gout 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 Breathing Problem 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 No Diabetes Yes No Prug Addiction Yes No Easily Winded Yes No Emphysema Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Erequent Headaches Yes No Equipment Headaches Yes No Excessive Thirst Y	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 Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Mo Osteoporosis Yes No Pain in Jaw Joints 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 Sickle Cell Disease  Yes  No Sinus Trouble  Yes  No Spina Bifida  Yes  No Stomach/Intestinal Disease  Yes  No Stroke  Yes  No Swelling of Limbs  Yes  No Thyroid Disease  Yes  No Tuberculosis  Yes  No Tuberculosis  Yes  No Venereal Disease  Yes  No Venereal Disease  Yes  No Yes  No Venereal Disease  Yes  No Yes  No Yes  No Yes  No
Comments:			
		rately answered. I understand that proe dental office of any changes in medical	
SIGNATURE OF PATIENT, PAREN	T or GUARDIAN		DATE