MEDICAL HISTORY

PATIENT NAME		Birth Date	
Although dental personnel primarily tre have, or medication that you may be to following questions.	eat the area in and around your mouth, aking, could have an important interrela	your mouth is a part of your entire bationship with the dentistry you will re	ody. Health problems that you may eceive. Thank you for answering the
Have you ever been hospitalized or had a Have you ever had a serious he Are you taking any medication Do you take, or have you taken, Ph Have you ever taken Fosamax, Bon other medications containing Are you	a major operation? Yes No If rad or neck injury? Yes No If ns, pills, or drugs? Yes No If en-Fen or Redux? Yes No If ns, actional or any No If No If ns, pills, or drugs?	yes, please explain:yes, please explain:	
Women: Are you Pregnant/Trying to get pregnant? \(\) Are you allergic to any of the following	Yes ○ No Taking oral contracept		○ Yes ○ No
Aspirin Penicillin Other If yes, please explain:	Codeine Local Anesthetics	Acrylic Metal	Latex Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Anemia Yes No Anemia Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Disease Yes No Blood Disease Yes No Breathing Problem Yes No Bruise Easily Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Conyulsions Yes No Have you ever had any serious illnes	Cortisone Medicine Yes No Diabetes Yes No Drug Addiction Yes No Easily Winded Yes No Emphysema Yes No Epilepsy or Seizures Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Fainting Spells/Dizziness Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Genital Herpes Yes No Glaucoma Yes No Haart Attack/Failure Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Ho	Hemophilia Yes No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Hives or Rash Yes No Hypoglycemia Yes No Irregular Heartbeat Yes No Kidney Problems Yes No Leukemia Yes No Liver Disease Yes No Low Blood Pressure Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Parathyroid Disease Yes No Psychiatric Care Yes No	Radiation Treatments
Comments:			
To the best of my knowledge, the que dangerous to my (or patient's) health	estions on this form have been accurate. It is my responsibility to inform the de	ely answered. I understand that provental office of any changes in medical	viding incorrect information can be I status.
SIGNATURE OF PATIENT, PARENT	C. CUADDIAN		DATE