## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
, , ,	•	nth, your mouth is a part of your entire relationship with the dentistry you will	
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medicati Do you take, or have you taken, P Have you ever taken Fosamax, Bo other medications containin Are yo	nead or neck injury? Yes No ons, pills, or drugs? Yes No when-Fen or Redux? Yes No oniva, Actonel or any Yes No u on a special diet? Yes No	If yes, please explain:	
	o you use tobacco? ( ) Yes ( ) No trolled substances? ( ) Yes ( ) No  Yes ( ) No Taking oral contract	eptives? Yes No Nursing	? O Yes O No
Are you allergic to any of the followin  Aspirin  Penicillin  Other If yes, please explain:	g? Codeine 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 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 Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Conyulsions Yes No Convulsions Illness Yes No Convulsions	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.  Heart Attack/Failure Yes N.  Heart Murmur Yes N.  Heart Pacemaker Yes N.  Heart Trouble/Disease 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 Shingles Yes No Sickle Cell Disease 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 Yes No Yellow Jaundice Yes No Yes No Yellow Jaundice Yes No Yes No Yes No Yes No Yes No Tumors or Growths Yes No Yes
Comments:			
		ately answered. I understand that pro dental office of any changes in medica	
SIGNATURE OF PATIENT, PARENT	Γ, or GUARDIAN		DATE