## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
	-	th, your mouth is a part of your entire l elationship with the dentistry you will r	
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medicatio Do you take, or have you taken, Ph Have you ever taken Fosamax, Bor other medications containing	a major operation? Yes No ead or neck injury? Yes No ons, pills, or drugs? Yes No hen-Fen or Redux? Yes No niva, Actonel or any	If yes, please explain:	
Do	o you use tobacco? Yes No prolled substances? Yes No		
Pregnant/Trying to get pregnant?	Yes No Taking oral contrace	eptives? Yes No Nursing?	? 🔿 Yes 🔿 No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	g? Codeine Local Anesthetic	cs 🗌 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         Anaphylaxis       Yes       No         Anemia       Yes       No         Anemia       Yes       No         Angina       Yes       No         Artificial Heart Valve       Yes       No         Artificial Joint       Yes       No         Asthma       Yes       No         Blood Disease       Yes       No         Blood Transfusion       Yes       No         Breathing Problem       Yes       No         Cancer       Yes       No         Chemotherapy       Yes       No         Congenital Heart Disorder       Yes       No         Convulsions       Yes       No         Have you ever had any serious illness       Comments:	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 Headaches       Yes       No         Genital Herpes       Yes       No         Glaucoma       Yes       No         Hay Fever       Yes       No         Heart Murmur       Yes       No         Heart Murmur       Yes       No         Heart Trouble/Disease       Yes       No	b       Hepatitis A       Yes       No         b       Hepatitis B or C       Yes       No         b       Herpes       Yes       No         b       High Blood Pressure       Yes       No         b       High Cholesterol       Yes       No         b       High Cholesterol       Yes       No         b       Hives or Rash       Yes       No         b       Hypoglycemia       Yes       No         b       Irregular Heartbeat       Yes       No         c       Leukemia       Yes       No         c       Liver Disease       Yes       No         c       Low Blood Pressure       Yes       No         c       Lung Disease       Yes       No         c       Mitral Valve Prolapse       Yes       No         c       Osteoporosis       Yes       No         c       Pain in Jaw Joints       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         Scarlet Fever       Yes       No         Sickle Cell Disease       Yes       No         Sinus Trouble       Yes       No         Stomach/Intestinal Disease       Yes       No         Stroke       Yes       No         Stroke       Yes       No         Storke       Yes       No         Stroke       Yes       No         Tuberculosis       Yes       No         Tumors or Growths       Yes       No         Venereal Disease       Yes       No         Yellow Jaundice       Yes       No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.