## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
		uth, your mouth is a part of your entire rrelationship with the dentistry you will	
Have you ever been hospitalized or ha Have you ever had a serious Are you taking any medica Do you take, or have you taken, Have you ever taken Fosamax, E other medications containi Are y	hysician's care now?  Yes No ad a major operation? Yes No head or neck injury? Yes No tions, pills, or drugs? Yes No Phen-Fen or Redux? Yes No ioniva, Actonel or any Yes No ioniva, Actonel or any Yes No ion on a special diet? Yes No Do you use tobacco? Yes No introlled substances? Yes No	If yes, please explain:  If yes, please explain:  If yes, please explain:  If yes, please explain:	
Pregnant/Trying to get pregnant?	Yes No Taking oral contract	ceptives? Yes No Nursing	? O Yes O No
Are you allergic to any of the follow     Aspirin Penicillin     Other If yes, please explain: _	ng?  Codeine  Local Anesther	tics Acrylic Meta	I Latex Sulfa drugs
AlDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Arthriticial Heart Valve Yes No Arthriticial Joint Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Cohemotherapy Yes No Cohest Pains Yes No Congenital Heart Disorder Yes No Convulsions Illing No Convulsions Yes No Convulsions Illing No Convulsions No Convulsions Illing No Convulsions No	Cortisone Medicine Yes No Diabetes Yes No Prug Addiction Yes No Pr	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 Hives or Rash Yes No Hypoglycemia Yes No Hregular Heartbeat Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Mo Osteoporosis Yes No Pain in Jaw Joints Yes No	Recent Weight Loss Yes No
Comments:			
		urately answered. I understand that pro e dental office of any changes in medic	
SIGNATURE OF PATIENT. PARE	NT. or GUARDIAN		DATE