## MEDICAL HISTORY

PATIENT NAME		Birth Date	
Although dental personnel primarily tre have, or medication that you may be to following questions.			The state of the s
Are you under a physical ave 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 lad or neck injury? Ye	If yes, please explain:  If yes, please explain:  If yes, please explain:	g? O Yes O No
Aspirin Penicillin	Codeine Local Anesthetic	cs Acrylic Meta	l Latex Sulfa drugs
Other If yes, please explain:			
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 Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint 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 Convulsions Yes No Have you ever had any serious illness	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease  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 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 Parathyroid Disease Yes No December No	Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Scarlet Fever Yes No Sinus Trouble Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Stroke Yes No Stroke Yes No Thyroid Disease Yes No Tonsillitis Yes No Tumors or Growths Yes No
Comments:			
		e dental office of any changes in medi	
SIGNATURE OF PATIENT, PAREN	T, or GUARDIAN		DATE