## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
• • • •	•	th, your mouth is a part of your entire t relationship with the dentistry you will r	
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medicatic Do you take, or have you taken, Pl Have you ever taken Fosamax, Bon other medications containing Are you	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 Yes No g bisphosphonates? Yes No u on a special diet? Yes No o you use tobacco? Yes No	If yes, please explain:	
Women: Are you Pregnant/Trying to get pregnant?	<u> </u>	pptives? () Yes () No Nursing?	? 🔿 Yes 🔿 No
Are you allergic to any of the following Aspirin Penicillin	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   Anemia Yes No   Angina Yes No   Ardiritis/Gout Yes No   Artificial Heart Valve Yes No   Artificial Joint Yes No   Asthma Yes No   Blood Disease Yes No   Blood Disease Yes No   Bruise Easily Yes No   Chemotherapy Yes No   Chest Pains Yes No   Codd Sores/Fever Blisters Yes No   Convulsions Yes No   Have you ever had any serious illnes Comments:	Cortisone Medicine Yes No   Diabetes Yes No   Drug Addiction Yes No   Easily Winded Yes No   Easily Winded Yes No   Epilepsy or Seizures Yes No   Excessive Bleeding Yes No   Excessive Bleeding Yes No   Fainting Spells/Dizziness Yes No   Frequent Cough Yes No   Frequent Diarrhea Yes No   Frequent Headaches Yes No   Glaucoma Yes No   Hay Fever Yes No   Heart Attack/Failure 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 Kidney Problems Yes No   b Leukemia Yes No   b Liver Disease Yes No   c Low Blood Pressure Yes No   c Lung Disease Yes No   c Lung Disease Yes No   c Osteoporosis Yes No   c Data Joints Yes No   c Na No Parathyroid Disease 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   Sickle Cell Disease Yes No   Sinus Trouble Yes No   Stomach/Intestinal Disease Yes No   Stroke Yes No   Stroke Yes No   Tumors or Growths Yes No   Ulcers 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.