MEDICAL HISTORY

PATIEN	NT NAME			Birth Da	te		
Although dental per have, or medication following questions.	n that you may be	reat the area in and aro taking, could have an ir	und your mou mportant inter	th, your mouth is a par relationship with the de	t of your entire bentistry you will re	ody. Health problems theceive. Thank you for an	at you may
Aı	re vou under a phy	vsician's care now?	Yes No	If yes, please explain:		× .	
Are you under a physician's care now? Yes Nave you ever been hospitalized or had a major operation? Yes N			_				
Have you ever had a serious head or neck injury? Yes No				If yes, please explain:			
•							
-		ons, pills, or drugs?					
Have you ever ta	ken Fosamax, Bo	hen-Fen or Redux? Oniva, Actonel or any	Yes No				
other medi		bisphosphonates?					
	•	u on a special diet?					
		you use tobacco?	~				
	Do you use con	trolled substances?	Yes No				
−Women: Are you − Pregnant/Trying to g	get pregnant?	Yes No Taking	oral contrace	eptives? Yes No	Nursing?	○ Yes ○ No	
Are you allergic to a	any of the following]?					
Aspirin	Penicillin	Codeine	cal Anestheti	cs Acrylic	Metal	Latex	Sulfa drugs
Other If yes, p							
Do you have, or have	ve you had any of	f the following?					
AIDS/HIV Positive	○ Yes ○ No I	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	Yes No	Diabetes	Yes No		Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No		Yes No	Renal Dialysis	Yes N
Anemia	Yes No	Easily Winded	Yes No		○ Yes ○ No	Rheumatic Fever	Yes N
Angina	Yes No	Emphysema	Yes No	· · · · · · · · · · · · · · · · · · ·	○ Yes ○ No	Rheumatism	Yes No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	Yes No		◯ Yes ◯ No	Scarlet Fever	○ Yes ○ N
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	Yes No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ N
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ N
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes N
Blood Disease	○ Yes ○ No	Frequent Cough	Yes No		○ Yes ○ No	Spina Bifida	○ Yes ○ N
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	Yes No		○ Yes ○ No	Stomach/Intestinal Diseas	
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	A CONTRACTOR OF THE CONTRACTOR	○ Yes ○ No	Stroke	○ Yes ○ N
Bruise Easily	○ Yes ○ No	Genital Herpes	Yes No		○ Yes ○ No	Swelling of Limbs Thyroid Disease	○ Yes ○ N
Cancer	○ Yes ○ No	Glaucoma	Yes No		Yes No	Tonsillitis	Yes N
Chemotherapy	○ Yes ○ No	Hay Fever	Yes No		Yes No	Tuberculosis	◯ Yes ◯ N
Chest Pains Cold Sores/Fever Bliste	Yes No	Heart Attack/Failure Heart Murmur	Yes No		Yes No	Tumors or Growths	Yes N
Congenital Heart Disord		Heart Pacemaker	Yes No		Yes No	Ulcers	○ Yes ○ N
Convulsions		Heart Trouble/Disease			Yes No	Venereal Disease	Yes N
		ss not listed above?		, , , , , , , , , , , , , , , , , , , ,		Yellow Jaundice	Yes No
Comments:							
To the best of my k	knowledge, the que	estions on this form hav	re been accur	ately answered. I unde	erstand that prov	iding incorrect information	on can be
	or patient's) nealth	. It is my responsibility	to inform the	dental office of any cha	anges in medical	siatus.	
SIGNATURE OF PA	ATIENT, PARENT	or GUARDIAN				DATE	