## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
		outh, your mouth is a part of your entire errelationship 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	head or neck injury? $\bigcirc$ Yes $\bigcirc$ No tions, pills, or drugs? $\bigcirc$ Yes $\bigcirc$ No Phen-Fen or Redux? $\bigcirc$ Yes $\bigcirc$ No	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 followi  Aspirin Penicillin  Other If yes, please explain: _	ng?————————————————————————————————————	tics Acrylic Meta	Latex Sulfa drugs
Do you have, or have you had, any AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Asthma 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 Conyulsions Yes No Convulsions Y	Cortisone Medicine Yes No labetes Ye	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 Hregular Heartbeat Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mo Mo Mo Liver Disease Yes No Mo Mitral Valve Prolapse Yes No No No No No No Pain in Jaw Joints Yes No Parathyroid Disease Yes No	Radiation Treatments
Comments:			
		rately answered. I understand that pro e dental office of any changes in medic	
SIGNATURE OF PATIENT, PAREN	IT or GUARDIAN		DATE