MEDICAL HISTORY

PATIENT NAME		Birth Date		
Although dental personnel primarily tro have, or medication that you may be t following questions.	•		•	
Have you ever been hospitalized or had Have you ever had a serious he Are you taking any medicatio Do you take, or have you taken, Ph Have you ever taken Fosamax, Bon other medications containing Are you Do	ead or neck injury? O Yes No ns, pills, or drugs? Yes No nen-Fen or Redux? Yes No	If yes, please explain: If yes, please explain: If yes, please explain:		
Women: Are you Pregnant/Trying to get pregnant?	/es ○ No Taking oral contra	ceptives? Yes No No	ursing? () Yes () No	
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:			Metal Latex	Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive Yes No AIzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion 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 illnes	Cortisone Medicine Diabetes Prug 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 Pacemaker Heart Trouble/Disease Yes I Pass I	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 Irregular Heartbeat Yes (No Kidney Problems Yes (No Leukemia Yes (No Liver Disease Yes (No Lung Disease Yes (No Mitral Valve Prolapse Yes (No Osteoporosis Yes (No Parathyroid Disease Yes (No Psychiatric Care Yes (No Recent Weight Loss No Renal Dialysis No Reumatic Fever No Rheumatism Scarlet Fever Shingles No Sickle Cell Disease Sinus Trouble Spina Bifida No Stomach/Intestinal Disease No Swelling of Limbs No N	Yes No
Comments:				
To the best of my knowledge, the que dangerous to my (or patient's) health.		-	. •	nation can be
SIGNATURE OF PATIENT, PARENT	or GUARDIAN		DATE	