## **MEDICAL HISTORY**

PATIENT NAME		Birth D	ate		
Although dental personnel primarily have, or medication that you may be following questions.					
Have you ever been hospitalized or hat Have you ever had a serious Are you taking any medicat Do you take, or have you taken, Have you ever taken Fosamax, Bother medications containii	head or neck injury? Yes tions, pills, or drugs? Yes Phen-Fen or Redux? Yes oniva. Actonel or any	No If yes, please explain No If yes, please explain No If yes, please explain No No No	n: n:		
-Women: Are you- Pregnant/Trying to get pregnant?	Yes No Taking oral cor	ntraceptives? Yes N	lo Nursing?	Yes No	
Are you allergic to any of the followi Aspirin Penicillin Other If yes, please explain:	ng?————————————————————————————————————	sthetics Acryl	ic Metal	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 Artificial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Conyenital Heart Disorder Yes No Convulsions Illnumber 1998 No Convulsions Yes No Convulsions Illnumber 1998 No Convulsions Yes No Convulsions Illnumber 1998 No Convulsions	Cortisone Medicine Yes Diabetes Yes Drug Addiction Yes Easily Winded Yes Emphysema Yes Epilepsy or Seizures Yes Excessive Bleeding Yes Excessive Thirst Yes Fainting Spells/Dizziness Yes Frequent Cough Yes Frequent Diarrhea Yes Genital Herpes Yes Glaucoma Yes Heart Attack/Failure Yes Heart Murmur Yes Heart Pacemaker Yes Heart Trouble/Disease Yes	No Hemophilia No Hepatitis A No Hepatitis B or C No Herpes No High Blood Pressure No High Cholesterol No Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease No Low Blood Pressure Lung Disease No Mitral Valve Prolaps No Osteoporosis Pain in Jaw Joints Parathyroid Disease No Psychiatric Care	Yes No	Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	Yes
Comments:					
To the best of my knowledge, the q dangerous to my (or patient's) heal			·	=	n can be
SIGNATURE OF PATIENT PAREN	T or CHAPDIAN			DATE	