MEDICAL HISTORY

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.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.											
Are you under a physician's care now?	Yes	No	If yes, please explain:								

Have you ever been hosp	oitalized	or had	a major operation?	Yes	No I	f yes, please explain:						
Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux?			Yes	No I	f yes, please explain:							
			Yes	No I	f yes, please explain:							
			Yes	No								
Are you on a special diet				Yes	No							
Do you use tobacco?				Yes	No							
2	hatanaaa	2										
Do you use controlled sul	ostances	6 <u>f</u>		Yes	No							
Women: Are you Pregr	nant/Tryi	ng to	get pregnant? Yes	s No	Takin	g oral contraceptives?	, ,	Yes	No Nursing?	Yes	No	
Are you allergic to any	of the fo	llowin	a?						-			
Aspirin F	Penicillin		Codeine A	Acrylic	Metal Latex			Local Anesthetics				
Other	f ves, ple	ase ex	plain:									
Do you have, or have yo		-	-									
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis		Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever		Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism		Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever		Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles		Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease		Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble		Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida		Yes	No
Asthma	Yes	No	Fainting Spells/Dizzines	ss Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal D	sease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke		Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs		Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease		Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis		Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis		Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths		Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers		Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease		Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice		Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No				
Have you ever had any s	erious illi	ness n	ot listed above?	Yes	No	lf yes, please explain	:					
Comments:												-

PATIENT NAME ______ Birth Date ______