MEDICAL HISTORY

PATIENT NAME		Birth Date	
		uth, your mouth is a part of your entire rrelationship with the dentistry you will	
Have you ever been hospitalized or ha Have you ever had a serious Are you taking any medicat Do you take, or have you taken, F Have you ever taken Fosamax, Bo other medications containin Are yo	head or neck injury? Yes No ions, pills, or drugs? Yes No Phen-Fen or Redux? Yes No oniva. Actonel or any	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
Women: Are you Pregnant/Trying to get pregnant?		ceptives? Yes No Nursing	? () Yes () No
Are you allergic to any of the followin Aspirin Penicillin Other If yes, please explain:	ng? Codeine Local Anesther	tics Acrylic 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 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 Convulsions Yes	Cortisone Medicine Yes No Diabetes Yes No Prug Addiction Yes No Easily Winded Yes No Emphysema Yes No Excessive Bleeding Yes No Excessive Bleeding Yes No Excessive Thirst Yes	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Lives or Rash Yes No High Cholesterol Yes No Lives or Rash Yes No Liver Disease Yes No Liver Disease Yes No Mitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Discourage Yes No	Radiation Treatments
Comments:			
		rately answered. I understand that pro e dental office of any changes in medica	
SIGNATURE OF PATIENT PAREN	IT or GUARDIAN		DATE