TIME 10:43 AM DATE 7/12/2011

## **MEDICAL HISTORY**

PATIENT NAME		Birth Date	
	-	nouth, your mouth is a part of your entire terrelationship with the dentistry you will	
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medication Do you take, or have you taken, Pl Have you ever taken Fosamax, Bou other medications containing	lead or neck injury? Yes Noons, pills, or drugs? Yes Noons, pills, or drugs? Yes Noons, pills, or drugs? Yes Noons, Actonel or any Yes Noons, Actonel or any	o If yes, please explain: o If yes, please explain: o If yes, please explain: o	
Do	u on a special diet?  Yes  No o you use tobacco?  Yes  No trolled substances?  Yes  No	0	
Pregnant/Trying to get pregnant?	Yes No Taking oral contra	aceptives? Yes No Nursing	g? O Yes O No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	Codeine Local Anesth	etics Acrylic Meta	al Latex Sulfa drugs
AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Artificial Heart Valve Yes No Asthma Yes No Blood Disease Yes No Breathing Problem Yes No Bruise Easily Yes No Congenital Heart Disorder Yes No Convulsions Yes No Convulsions Yes No Have you ever had any serious illness	Cortisone Medicine Yes Diabetes Yes Orug 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	No Hepatitis A Yes No No Hepatitis B or C Yes No No Herpes Yes No No High Blood Pressure Yes No No High Cholesterol Yes No No Hives or Rash Yes No No Hypoglycemia Yes No No Irregular Heartbeat Yes No No Leukemia Yes No Low Blood Pressure Yes No No Liver Disease Yes No No Lung Disease Yes No No Mitral Valve Prolapse Yes No No Osteoporosis Yes No No Pain in Jaw Joints Yes No No Parathyroid Disease Yes No No No No Parathyroid Disease Yes No No No No Parathyroid Disease Yes No No No No Parathyroid Disease Yes No No No Parathyroid Disease Yes No	Recent Weight Loss
Comments:			
		curately answered. I understand that pr he dental office of any changes in medic	
SIGNATURE OF PATIENT, PAREN	T, or GUARDIAN		DATE