## MEDICAL HISTORY

PATIENT		Birth Date							
Although dental person have, or medication the following questions.	onnel pi nat you	rimarily t i may be	reat the area in and arou taking, could have an in	und your mo	outh, errela	your mouth is a part	of your entire b	ody. Health problems that eceive. Thank you for ans	at you may swering the
Aro	VOLUM	dor a nh	ysician's care now?	Yes No	lf.	yes, please explain:			
lave you ever been hos		Yes No		yes, please explain:					
		Yes No		yes, please explain:			11-1-1		
and the second				and the second s					
	-			Yes No		yes, please explain:			
Have you ever take	n Fosa	max, Bo	niva Actonel or any	Yes No	-				
	Are vo	u on a special diet?	Yes No	)					
				Yes No	)				
	Do vou			Yes No					
Women: Are you	50 ,00	000 001	donot dobotaneou.						
Pregnant/Trying to ge	t pregn	nant?	Yes No Taking	oral contra	cept	ives? Yes No	Nursing?	○ Yes ○ No	
Are you allergic to any	y of the	followin	g?						
	Penicilli			cal Anesthe	etics	Acrylic	Metal	Latex	Sulfa drugs
Other If yes, plea									
	******				-				
Do you have, or have	you ha	ad, any o	f the following?						
AIDS/HIV Positive	O Yes	s No	Cortisone Medicine		No	Hemophilia	Yes No	Radiation Treatments	Yes N
Alzheimer's Disease	O Yes	s O No	Diabetes		No	Hepatitis A	Yes No	Recent Weight Loss	O Yes O N
Anaphylaxis	O Yes	s O No	Drug Addiction		No	Hepatitis B or C	Yes No	Renal Dialysis	O Yes O N
knemia	Yes	s No	Easily Winded	Yes O	No	Herpes	Yes No	Rheumatic Fever	Yes N
Angina	O Yes	s No	Emphysema	O Yes	No	High Blood Pressure	Yes No	Rheumatism	O Yes O N
Arthritis/Gout	Yes	s No	Epilepsy or Seizures		No	High Cholesterol	Yes No	Scarlet Fever	○ Yes ○ N
Artificial Heart Valve	Yes	s No	Excessive Bleeding	-	No	Hives or Rash	Yes No	Shingles	○ Yes ○ N
Artificial Joint	O Yes		Excessive Thirst		No	Hypoglycemia	Yes No	Sickle Cell Disease	O Yes O N
Asthma	Yes		Fainting Spells/Dizziness		No	Irregular Heartbeat	Yes No	Sinus Trouble	O Yes O N
Blood Disease	O Yes		Frequent Cough		No	Kidney Problems	Yes No	Spina Bifida	Yes O N
Blood Transfusion	O Yes		Frequent Diarrhea		No	Leukemia	Yes No	Stomach/Intestinal Disease	
Breathing Problem	Yes		Frequent Headaches		No	Liver Disease	Yes No	Stroke	Yes O N
Bruise Easily	( ) Yes		Genital Herpes		No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes N
Cancer	O Yes		Glaucoma		No	Lung Disease	Yes No	Thyroid Disease Tonsillitis	Yes N
Chemotherapy	O Yes		Hay Fever		No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	O Yes O N
Chest Pains	O Yes		Heart Attack/Failure		No	Osteoporosis	○ Yes ○ No	Tumors or Growths	O Yes O N
Cold Sores/Fever Blisters			Heart Murmur		No	Pain in Jaw Joints	O Yes O No	Ulcers	O Yes O N
Congenital Heart Disorder			Heart Pacemaker		No	Parathyroid Disease	Yes No	Venereal Disease	O Yes O N
Convulsions	O Yes	s No	Heart Trouble/Disease	O Yes O	No I	Psychiatric Care	Yes No	Yellow Jaundice	○ Yes ○ N
Have you ever had a	any ser	ious illne	ss not listed above?	Yes No	0				
Comments:									
							177		
_									
					_		-		
To the best of my kn	owledg	e. the o	estions on this form have	e been acc	curate	ely answered. I unde	erstand that prov	viding incorrect informatio	n can be
dangerous to my (or	patien	t's) healt	h. It is my responsibility	to inform th	ne de	ental office of any cha	inges in medica	status.	TOTAL
dangerous to my (or	patient	. o, mount	it is in a coponionally			or or arry oric	3		
SIGNATURE OF PA	TIENT	PAREN	T, or GUARDIAN					DATE	