MEDICAL HISTORY

PATIENT NAME	Birth Date
	your mouth, your mouth is a part of your entire body. Health problems that you may rtant interrelationship with the dentistry you will receive. Thank you for answering the
Are you under a physician's care now? Have you ever been hospitalized or had a major operation? 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? Are you on a special diet? Do you use tobacco? Do you use controlled substances?	Yes No If yes, please explain: Yes No If yes, please explain: Yes No If yes, please explain: Yes No Yes No Yes No
	oral contraceptives? O Yes O No Nursing? O Yes O No
Are you allergic to any of the following? Aspirin Penicillin Codeine Ac Other If yes, please explain:	rylic Metal Latex Local Anesthetics
Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Breathing Problem Yes No Bruise Easily Yes No Chemotherapy Yes No Chest Pains Yes No Congenital Heart Disorder Yes No Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker	Yes No Leukemia Yes No Stroke Yes No Yes No Liver Disease Yes No Swelling of Limbs Yes No Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Yes No Lung Disease Yes No Tonsillitis Yes No Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes No Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No Yes No Parathyroid Disease Yes No Venereal Disease Yes No Yes No Radiation Treatments Yes No Yellow Jaundice Yes No
To the best of my knowledge, the questions on this form have b dangerous to my (or patient's) health. It is my responsibility to it	neen accurately answered. I understand that providing incorrect information can be inform the dental office of any changes in medical status.

_____ DATE _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____