MEDICAL HISTORY

PATIENT NAME		Birth Date	
		your mouth is a part of your entire body ationship with the dentistry you will recei	
Have you ever been hospitalized or hat Have you ever had a serious Are you taking any medica Do you take, or have you taken, Are you	hysician's care now? Yes No Ad a major operation? Yes No head or neck injury? Yes No tions, pills, or drugs? Yes No Phen-Fen or Redux? Yes No You on a special diet? Yes No Do you use tobacco? Yes No ntrolled substances?	If yes, please explain: If yes, please explain: If yes, please explain:	
Women: Are you Pregnant/Trying to get pregnant?		eptives? Yes No Nursin	g? O Yes No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	? Codeine Acrylic	Metal Latex Loc	al Anesthetics
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 Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Breathing Problem Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Convulsions Yes No Convulsions Illr	the following? Cortisone Medicine Yes No Diabetes Yes No Prug Addiction Yes No Prug Add	Hepatitis A Yes No. Hepatitis B or C Yes No. Herpes Yes No. Herpes Yes No. High Blood Pressure Yes No. High Blood	Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Scarlet Fever Yes No Sinus Frouble Yes No Spina Bifida Yes No Storoke Yes No Storoke Yes No Storoke Yes No Thyroid Disease Yes No Tonsillitis Yes No Tuberculosis Yes No Ulcers Yes No Yes No Yes No Venereal Disease Yes No Yes No Venereal Disease Yes No Yes No Yes No
Comments:			
		· · · · · · · · · · · · · · · · · · ·	
		ely answered. I understand that providental office of any changes in medical st	
SIGNATURE OF PATIENT, PAREN	T. or GUARDIAN		DATE