MEDICAL HISTORY

Although denial personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you under a physician's care now? Yes No If yes, please explain: Have you ever had a serious head or nock ripley? Yes No If yes, please explain: Are you taken gan y medications, pills, or drugs? Yes No No If yes, please explain: Do you take, or have you taken. Phen-Fen or fleetur? Yes No Do you use totalocor? Yes No No Nursing? Yes Nursing? Yes Nursing? Yes Nursing? Yes Nursing? Yes Nursing? Yes Nursi	PATIENT NAME	·		Birth Da	te		
have, or medication that you may be taking, could have an important interrelationship with the dentisity you will receive. Thank you for answering the following questions. Are you under a physician's care now? Yes No If yes, please explain:							
Have you aver bear hospitalized or had a major operation? Yes No flyes, please explain:	have, or medication that you m	•			•		•
Women: Are you Pregnant/Trying to get pregnant? Yes	Have you ever been hospitaliz Have you ever had a Are you taking any	ed or had a major operation? serious head or neck injury? medications, pills, or drugs? taken, Phen-Fen or Redux? Are you on a special diet?	Yes \(\) No If Yes \(\) No Yes \(\) No	yes, please explain: yes, please explain:			
	Do you	·					
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? AlDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Renal Dialysis Yes No Alzheimer's Disease Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Playsis Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Remail Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Remail Yes No Hepatitis B or C Yes No Remail Yes No Hepatitis B or C Yes No Remail Yes No Hepatitis B or C Yes No Remail Yes No Hepatitis B or C Yes No Remail Yes No Hepatitis B or C Yes No No Remail Yes No Hepatitis B or C Yes No No Remail Yes No Hepatitis B or C Yes No No Remail Yes No Hepatitis B or C Yes No No Remail Yes No No Hepatitis B or C Yes No No Scalet Fever Yes No No Arthritial Solution Yes No No Excessive Bleeding Yes No No Helmos Of Remail Yes No No Fraguent Plays No No Fraguent Plays Yes No No Remailing Problem Yes No No Gancer Yes No No Galeucoma Yes No No Galeucoma Yes No No Galeucoma Yes No No Galeucoma Yes No No Heart Altack/Failure Yes No Recent Weight Lever Jesses Yes No No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No No Convolutions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No No Convolutions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No No Convolutions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No No Convolutions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No No Convolutions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yes No Yes No Yes No Heart Trouble/Disease Yes No No Recent Weight Loss Yes No Yes No Yes No Yes No Yes No Heart Trouble/Disease Yes No No Recent Weight Loss Yes No	Women: Are you			ves? Yes N	o Nursing?	○ Yes ○ No	
Other If yes, please explain:	Are you allergic to any of the fo	llowing?					
Do you have, or have you had, any of the following? AllOSHIV Positive			crylic N	letal Latex	Local	Anesthetics	
AlDSHIVP Positive Yes No Cortisone Medicine Yes No Herpatitis A Yes No Herpatitis B or Yes No Andminal Yes No Secrit Fever Yes No Arthritis/Gout Yes No Secrit Fever Yes No Arthritis/Gout Yes No Secrit Fever Yes No Arthritis/Gout Yes No Secrit Fever Yes No Herpatitis B or Yes No Herpatitis B or Yes No No Herpatitis B or Yes No No Herpatitis B or Yes No Kidney Problems Yes No No Herpatitis B or Yes No Herpatitis B or Yes	Other II yes, please expla						
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	AIDS/HIV Positive Yes (Alzheimer's Disease Yes (Anaphylaxis Yes (Anemia Yes (Angina Yes (Arthritis/Gout Yes (Artificial Heart Valve Yes (Artificial Joint Yes (Asthma Yes (Blood Disease Yes (Blood Transfusion Yes (Breathing Problem Yes (Breathing Problem Yes (Cancer Yes (Chemotherapy Yes (Cold Sores/Fever Blisters Yes (Conyulsions Yes (Convulsions Yes (Conversed Yes	No Cortisone Medicine No Diabetes No Drug Addiction Easily Winded No Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst No Frequent Cough No Frequent Diarrhea No Frequent Headaches Genital Herpes No Glaucoma Hay Fever No Heart Attack/Failure Heart Pace Maker No Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes No Heart Attack/Failure Heart Pace Maker No Heart Trouble/Disease	Yes \ No \ Yes \ Yes \ No \ Yes \ Yes \ No \ Yes \ No \ Yes \ Yes \ Yes \ No \ Yes \ Y	Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatment Recent Weight Loss	Yes No	Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Diseas Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	Yes No Yes No
dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Comments:						
dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.							
SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE							ı be
DAIL OF TAILETT, TAILETT, OF OUR ADMIT	SIGNATURE OF PATIENT P	ARENT or GUARDIAN				DATE	