HIME 10:43 AM DATE //12/2011

## **MEDICAL HISTORY**

| PATIENT NAME  |   | Birth Date   |                      |
|---|---|--|----------------------|
|   |   | uth, your mouth is a part of your entire relationship with the dentistry you will i  |                      |
| lave you ever been hospitalized or ha Have you ever had a serious Are you taking any medicat Do you take, or have you taken, I Have you ever taken Fosamax, Bo other medications containin Are you Do you use co  | head or neck injury? Yes No<br>ions, pills, or drugs? Yes No<br>Phen-Fen or Redux? Yes No<br>oniva, Actonel or any  | If yes, please explain:  If yes, please explain:  If yes, please explain:  If yes, please explain:   |                      |
| ─Women: Are you<br>Pregnant/Trying to get pregnant?   | Yes No Taking oral contract   | eptives? Yes No Nursing  | ? O Yes O No         |
| Are you allergic to any of the following Aspirin Penicillin  Other If yes, please explain:  | ng?  Codeine  Local Anesthet  | ics Acrylic Metal  | Latex Sulfa drugs    |
| AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis 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 Bruise Easily Yes No Grancer Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Convulsions | Cortisone Medicine Yes N Diabetes Yes N Drug Addiction Yes N Easily Winded Yes N Emphysema Yes N Epilepsy or Seizures Yes N Excessive Bleeding Yes N Excessive Thirst Yes N Fainting Spells/Dizziness Yes N Frequent Cough Yes N Frequent Diarrhea Yes N Frequent Headaches Yes N Genital Herpes Yes N Glaucoma Yes N Hay Fever Yes N Heart Attack/Failure Yes N Heart Murmur Yes N Heart Pacemaker Yes N | Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Hives or Rash Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No O Steoporosis Yes No O Parathyroid Disease Yes No | Radiation Treatments |
| Comments:   |   |  |                      |
|   |   | rately answered. I understand that pro<br>dental office of any changes in medica   | =                    |