MEDICAL HISTORY

PATIENT NAME	Birth Date
	nouth, your mouth is a part of your entire body. Health problems that you may nterrelationship with the dentistry you will receive. Thank you for answering the
Are you under a physician's care now? Yes Have you ever been hospitalized or had a major operation? Yes Have you ever had a serious head or neck injury? Yes Are you taking any medications, pills, or drugs? Yes Do you take, or have you taken, Phen-Fen or Redux? Yes Are you on a special diet? Yes Do you use tobacco? Yes Do you use controlled substances? Yes Women: Are you	No If yes, please explain: No If yes, please explain: No If yes, please explain: No
Pregnant/Trying to get pregnant? Yes No Taking oral co	ontraceptives? O Yes O No Nursing? O Yes O No
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Other If yes, please explain:	Metal Latex Local Anesthetics
Alzheimer's Disease Yes No Diabetes Yes Anaphylaxis Yes No Drug Addiction Yes Anemia Yes No Easily Winded Yes Angina Yes No Easily Winded Yes Arthritis/Gout Yes No Emphysema Yes Artificial Heart Valve Yes No Excessive Bleeding Yes Artificial Joint Yes No Excessive Thirst Yes Asthma Yes No Fainting Spells/Dizziness Yes Blood Disease Yes No Frequent Cough Yes Bruise Easily Yes No Genital Herpes Yes Cancer Yes No Glaucoma Yes Yes Chemotherapy Yes No Glaucoma Yes Yes Chest Pains Yes No Heart Attack/Failure Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes Congenital Heart Disorder Yes No Heart Murmur Y	S No Leukemia Yes No Stroke Yes No S No Liver Disease Yes No Swelling of Limbs Yes No S No Low Blood Pressure Yes No Swelling of Limbs Yes No S No Low Blood Pressure Yes No Thyroid Disease Yes No S No Lung Disease Yes No Tonsillitis Yes No S No Mitral Valve Prolapse Yes No Tuberculosis Yes No S No Pain in Jaw Joints Yes No Tumors or Growths Yes No S No Parathyroid Disease Yes No Venereal Disease Yes No S No Radiation Treatments Yes No Yes No S No Recent Weight Loss Yes No Yes No
Comments:	
To the best of my knowledge, the questions on this form have been as dangerous to my (or patient's) health. It is my responsibility to inform	ccurately answered. I understand that providing incorrect information can be the dental office of any changes in medical status.