## **MEDICAL HISTORY**

Alzheimer's Disease Yes No Diabetes Yes No Diabetes Yes No Anaphylaxis Yes No Drug Addiction Yes No Drug Addic	PATIENT NAME			Birth Da	ate		
Save you were bean hospitalized or had a major operation?   Yes   No   If yes, please explain:	have, or medication that you may be						
Pregnant/Trying to get pregnant? \ Ves \ No \ Taking oral contraceptives? \ Yes \ No \ Nursing? \ Yes \ No \ Nursing? \ Yes \ No \ Nursing? \ Yes \ No \ No \ No \ Nursing? \ Yes \ No \ No \ No \ Nursing? \ Yes \ No \ N	Have you ever been hospitalized or ha Have you ever had a serious Are you taking any medicat Do you take, or have you taken, F Have you ever taken Fosamax, Bo other medications containing Are you Do you use con	d a major operation? Yes of head or neck injury? Yes of head or neck injury? Yes of head or neck injury? Yes of hen-Fen or Redux? Yes of hen-Fen or Redux? Yes of hen	No If yes, p No If yes, p No If yes, p No If yes, p No No No No	olease explain: olease explain:			
Aspirin   Penicillin   Codeine   Local Anesthetics   Acrylic   Metal   Latex   Sulfa drugs	_	Yes No Taking oral	contraceptives?	◯ Yes ◯ N	o Nursing?	◯ Yes ◯ No	
AlDs/HIV Positive Yes No Cathone Medicine Yes No Hemophilia Yes No Hepatitis A Yes No Diabetes	Aspirin Penicillin		nesthetics	Acrylic	c Metal	Latex	Sulfa drugs
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         No           Alzheimer'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           Bruise Easily         Yes         No           Cancer         Yes         No           Chemotherapy         Yes         No           Chest Pains         Yes         No           Cold Sores/Fever Blisters         Yes         No           Convulsions         Yes         No	Cortisone Medicine You Diabetes You Diabetes You Drug Addiction You Easily Winded You Emphysema You Epilepsy or Seizures You Excessive Bleeding You Excessive Thirst You Fainting Spells/Dizziness You Frequent Cough You Frequent Diarrhea You Frequent Headaches You Genital Herpes Glaucoma You Hay Fever You Heart Attack/Failure You Heart Murmur You Heart Pacemaker You Heart Trouble/Disease You	es No Hep	atitis A atitis B or C bes a Blood Pressure c Cholesterol as or Rash oglycemia gular Heartbeat ar Disease Blood Pressure g Disease al Valve Prolapse coporosis athyroid Disease	Yes No	Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Dis Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease	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:						<u> </u>
CIONATURE OF RATIONE RAPENT. CHARRIAN	dangerous to my (or patient's) healt	h. It is my responsibility to inf					nation can be