MEDICAL HISTORY

PATIENT NAME		Birth Date	
	at the area in and around your mouth, y king, could have an important interrelat		
Have you ever been hospitalized or hat Have you ever had a serious Are you taking any medicat Do you take, or have you taken, F	d a major operation? Yes No head or neck injury? Yes No ions, pills, or drugs? Yes No Phen-Fen or Redux? Yes No ou on a special diet? Yes No	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
	Oo you use tobacco? () Yes () No ntrolled substances? () Yes () No		
-Women: Are you	itiolied substances: Tes Tro		
Pregnant/Trying to get pregnant?	Yes O No Taking oral contracep	otives? O Yes O No Nursi	ng? O Yes O No
Are you allergic to any of the following? Aspirin Penicillin Other If yes, please explain:		Metal Latex Lo	ocal Anesthetics
	Cortisone Medicine Yes No Diabetes Yes No Drug Addiction Yes No Easily Winded Yes No Emphysema Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Frainting Spells/Dizziness Yes No Frequent Cough Yes No Frequent Headaches Yes No Genital Herpes Yes No Glaucoma Yes No Hay Fever Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pace Maker Yes No	Hepatitis A Yes N Hepatitis B or C Yes N Herpes Yes N High Blood Pressure Yes N Hives or Rash Yes N Hypoglycemia Yes N Irregular Heartbeat Yes N Leukemia Yes N Leukemia Yes N Low Blood Pressure Yes N Lung Disease Yes N Mitral Valve Prolapse Yes N Pain in Jaw Joints Yes N Parathyroid Disease Yes N Parathyroid Disease Yes N Psychiatric Care Yes N Recent Weight Loss Yes N	Rheumatic Fever Yes No Rheumatism Yes No Rheumatism Yes No Scarlet Fever Yes No Scarlet Fever Yes No Sickle Cell Disease Yes No Sickle Cell Disease Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stowach Since Yes No Thyroid Disease Yes No Tonsillitis Yes No Tuberculosis Yes No Ulcers Yes No Ulcers Yes No Venereal Disease Yes No
Comments:			
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.			

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE _____