TIME 10:43 AM DATE 7/12/2011

MEDICAL HISTORY

PATIENT NAME		Birth Date	
	eat the area in and around your mouth, your mout aking, could have an important interrelationship w		• •
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medication Do you take, or have you taken, Pl Have you ever taken Fosamax, Bou other medications containing	ead or neck injury? Yes No If yes, please ns, pills, or drugs? Yes No If yes, please nen-Fen or Redux? Yes No	e explain: e explain:	
Do	you use tobacco? Yes No No No No No No	'es ○ No Nursing? ○ Yes ○ No	
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	? Codeine Local Anesthetics	Acrylic Metal Latex	Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive Yes No AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Anemia Yes No Arthritis/Gout 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 Chemotherapy Yes No Congenital Heart Disorder Yes No Convulsions Yes No Have you ever had any serious illness	Cortisone Medicine Yes No Hemophilis Diabetes Yes No Hepatitis A Drug Addiction Yes No Hepatitis A Hepatitis A Drug Addiction Yes No Herpes No High Blood A High Blood A High Chole Excessive Bleeding Yes No Hives or A High Chole Excessive Thirst Yes No Hypoglyce Fainting Spells/Dizziness Yes No Hypoglyce Frequent Cough Yes No Kidney Profequent Diarrhea Yes No Leukemia Frequent Headaches Yes No Low Blood Glaucoma Yes No Lung Disea Calaucoma Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Pain in Jan Heart Pacemaker Yes No Parathyron Heart Trouble/Disease Yes No Psychiatric	Recent Weight Los Renal Dialysis Renal Dialysis Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shot Sash Yes No Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Stroke Serial Yes No Rese Yes No Rese Yes No Rese Yes No Rese Yes No Resis Yes No Resis Yes No Rese Yes No Resis Yes No Resease Research Yes No Resease Ye	Yes No Yes Ye
Comments:			
	estions on this form have been accurately answere It is my responsibility to inform the dental office of		ormation can be
SIGNATURE OF PATIENT, PAREN	, or GUARDIAN	DATE	