



MEDICAL HISTORY

PATIENT N	AME			Birth Da	te		
Although dental person		of the area in and arou	nd your mouth	your mouth is a par	t of your entire bo	ody. Health problems th	at you may
have, or medication that following questions.	nei primarily tre at you may be ta	king, could have an im	portant interrel	ationship with the de	ntistry you will re	ceive. Thank you for ar	iswering the
Are yo	ou under a phys	ician's care now?					
ave you ever been hospitalized or had a major operation? Yes No Have you ever had a serious head or neck injury? Yes No				yes, piease explain.			
				yes, please explain:			
Are you taking	any medication	ns, pills, or drugs?					
Have you over taken	Fosamay Roni	en-Fen or Redux? va, Actonel or any bisphosphonates?	Yes No -				
Other modicati		on a special diet?	Yes O No				
	•	you use tobacco?					
n		olled substances?					
Women: Are you	o you use conti	onea sabstanoos.			the last of the la	er der der Aufgeste der Stemmen der der der Stemmen der Stemmen der der Stemme	man and Approximate and Manager Control of the cont
Pregnant/Trying to get	pregnant? 🔘 Y	es No Taking	oral contracep	tives? Yes N	o Nursing?	○ Yes ○ No	engleser (All suppressed a monophilities of the second field of the second second and second
Are you allergic to any	of the following		anness (sensente antique esta esta esta esta esta esta esta est				
Aspirin Pe	enicillin	Codeine Lo	cal Anesthetics	S Acryli	c Metal	Latex	Sulfa drugs
Other If yes, plea	se explain:						
Do you have, or have y	ou had, any of	the following?		and the special profession and a survey of an executive and an executive profession and an experimental		тупуруун аруулган арын арын арын арын арын арын арын ар	
	Yes No	Cortisone Medicine		Hemophilia	○ Yes ○ No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	Yes No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	
Angina	Yes No	Emphysema	O Yes O No	High Blood Pressure	ā 6	Rheumatism Scarlet Fever	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol		Shingles	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Artificial Joint	Yes No	Excessive Thirst Fainting Spells/Dizziness	\simeq	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	Yes No
Asthma (Yes ○ No Yes ○ No	Frequent Cough	Yes No	Kidney Problems	○ Yes ○ No	Spina Bifida	Yes No
Blood Disease Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	O Yes O No	Stomach/Intestinal Disea	se 🔵 Yes 🔘 No
Breathing Problem	Yes No	Frequent Headaches	○ Yes ○ No	Liver Disease	O Yes O No	Stroke	
3	Yes No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	Yes No	Swelling of Limbs	O Yes O No
Bruise Easily Cancer	Yes No	Glaucoma	○ Yes ○ No	Lung Disease	O Yes O No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolaps	e Yes No	Tonsillitis	○ Yes ○ No
	Yes No	Heart Attack/Failure	O Yes O No	Osteoporosis	○ Yes ○ No	Tuberculosis Tumors or Growths	Yes No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	O Yes O No		Yes No	Ulcers	Yes No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	O Yes O No			Venereal Disease	Yes No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care		Yellow Jaundice	O Yes O No
Have you ever had a	ny serious illnes	s not listed above?	Yes O No	in the contraction of the contraction of the state of the contraction			
Comments:							
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T. 4b - b	uuladaa tha	nations on this form he	ve heen accur	ately answered. Lun	derstand that pro	viding incorrect information	tion can be
dangerous to my (or	patient's) health	. It is my responsibility	to inform the	dental office of any c	hanges in medica	al status.	
	FIELD DADELT	· · · OLIADDIAN				DATE	
SIGNATURE OF PAT	HENT, PARENT	, or GUARDIAN					