## MEDICAL HISTORY

PATIENT NAME				Birth Date		
have, or medication	n that you may be				re body. Health problems that you may rill receive. Thank you for answering the	
following questions						
A	re you under a ph	ysician's care now?	Yes O No	If yes, please explain:		
ave you ever been hospitalized or had a major operation? Yes No				If yes, please explain:		
Have you ever had a serious head or neck injury?   Yes   No						
Are you taking any medications, pills, or drugs?   Yes   I   Do you take, or have you taken, Phen-Fen or Redux?   Yes   I						
		o you use tobacco?				
10/2	Do you use con	trolled substances?	Yes No		the same and the same	
Women: Are you Pregnant/Trying to	get pregnant?	Yes No Takin	g oral contrace	eptives? Yes No Nursir	ng? () Yes () No	
Are you allergic to a	any of the followin	g?				
Aspirin	Penicillin	Codeine A	crylic	Metal Latex Loc	cal Anesthetics	
Other If yes, p	dagaa ayalalay					
Other II yes, p	olease explain:					
Do you have, or ha	we you had any o	f the following?				
AIDS/HIV Positive	Yes No		O Ves O Ne	Lu	In the contract of the contrac	
Alzheimer's Disease	Yes No	Cortisone Medicine Diabetes	Yes  No     Yes  No     No			
Anaphylaxis	○ Yes ○ No	Drug Addiction	Yes No			
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No			
Angina	○ Yes ○ No	Emphysema	◯ Yes ◯ No			
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No		o Sickle Cell Disease Yes N	
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	,, ,,		
Artificial Joint Asthma	○ Yes ○ No	Excessive Thirst	○ Yes ○ No			
Blood Disease	○ Yes ○ No ○ Yes ○ No	Fainting Spells/Dizzines Frequent Cough	s Yes No			
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	Yes No	<u> </u>		
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No			
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No			
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse Yes No	o Tuberculosis O Yes O No	
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No		Tumors or Growths Yes No	
Chest Pains Cold Sores/Fever Bliste	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No			
Congenital Heart Disord	$\sim$	Heart Murmur Heart Pace Maker	Yes  No     Yes  No     No			
Convulsions	Yes No	Heart Trouble/Disease	O Yes O No		A TOTAL CONTROL OF THE PARTY OF	
Have you ever bee						
have you ever had	any serious iline	ss not listed above?	Yes ( No I	r yes, please explain:		
V 151.						
Comments:						
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To the best of and						
dangerous to my k	or nation!'s) hoolth	estions on this form ha	ve been accura	ately answered. I understand that p dental office of any changes in med	providing incorrect information can be	
dangerous to my (C	n paueins) nealth	. It is my responsibility	to inform the d	uerital office of any changes in medi	icai status.	
SIGNATURE OF P	ATIENT, PAREN	T, or GUARDIAN			DATE	