MEDICAL HISTORY

| PATIENT NAME | | Birth Date | |
|--|---|--|---|
| | y treat the area in and around your mou be taking, could have an important inter | | |
| Have you ever been hospitalized or have you ever had a serious Are you taking any medica Do you take, or have you taken, Have you ever taken Fosamax, E other medications containi Are y | s head or neck injury? Yes No ations, pills, or drugs? Yes No Phen-Fen or Redux? Yes No Boniva, Actonel or any Yes No rou on a special diet? Yes No Do you use tobacco? Yes No ontrolled substances? Yes No | If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain: | ı? ○ Yes ○ No |
| Are you allergic to any of the follow | ing? | | |
| Aspirin Penicillin Other If yes, please explain: | Codeine Local Anestheti | | l Latex Sulfa drugs |
| 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 Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Convulsions Yes No Convulsions Yes No Chapter And And Serious illn | Diabetes Yes No. Drug Addiction Yes No. Easily Winded Yes No. Emphysema Yes No. Epilepsy or Seizures Yes No. Excessive Bleeding Yes No. Excessive Thirst Yes No. Frequent Cough Yes No. Frequent Diarrhea 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 Murmur Yes No. Heart Pacemaker Yes No. | Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Parathyroid Disease Yes No | Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Yes No |
| Comments: | · | | |
| To the best of my knowledge, the q | uestions on this form have been accura | ately answered. I understand that produce the following of any changes in modern | oviding incorrect information can be |
| SIGNATURE OF PATIENT, PAREN | W-d- | uental office of any changes in medica | DATE |