MEDICAL HISTORY

PATIENT NAME		Birth Date	
			body. Health problems that you may receive. Thank you for answering the
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medicatic Do you take, or have you taken, Ph Have you ever taken Fosamax, Bor other medications containing Are you	a major operation? Yes No I ead or neck injury? Yes No I ons, pills, or drugs? Yes No I nen-Fen or Redux? Yes No	f yes, please explain: f yes, please explain: f yes, please explain: f yes, please explain:	
Pregnant/Trying to get pregnant?	Yes O No Taking oral contracep	otives? Yes No Nursing	g? O Yes O No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:	Codeine Local Anesthetic	s Acrylic Meta	l Latex Sulfa drugs
AIDS/HIV Positive Yes No Anaphylaxis Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Blood Disease Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Breathing Problem Yes No Cancer Yes No Cancer Yes No Condenderapy Yes No Cold Sores/Fever Blisters Yes No Congenital Heart Disorder Yes No Convulsions Yes No Have you ever had any serious illness	Cortisone Medicine Yes No 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 Fainting Spells/Dizziness Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Genital Herpes Yes No Glaucoma Yes No Hay Fever Yes No Heart Attack/Failure Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No	Hemophilia Yes No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No Hiyes or Rash Yes No Hypoglycemia Yes No Irregular Heartbeat Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Pain in Jaw Joints Yes No Psychiatric Care No	Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Schingles Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tonsillitis Yes No Tumors or Growths Yes No Versilling No Ver
	estions on this form have been accura . It is my responsibility to inform the d		
SIGNATURE OF PATIENT, PAREN	Cor GUARDIAN		DATE