MEDICAL HISTORY

PATIENT NAME		Birth Date	
have, or medication that you may be to		your mouth is a part of your entire body. tionship with the dentistry you will receiv	
Have you ever been hospitalized or had a major operation? Yes No Have you ever had a serious head or neck injury? Yes No		If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
	ntrolled substances? Yes No	ptives? Yes No Nursing	? O Yes O No
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:			
	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. Frequent Headaches Yes No. Genital Herpes Yes No. Glaucoma Yes No. Hay Fever Yes No. Heart Attack/Failure Yes No. Heart Murmur Yes No.	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No Hives or Rash Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Parathyroid Disease Yes No Psychiatric Care Yes No Radiation Treatments Yes No	Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Shingles Yes No Sickle Cell Disease Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tuberculosis Yes No Tumors or Growths Yes No Venereal Disease Yes No Yes No Vellow Jaundice Yes No
		ly answered. I understand that providinatal office of any changes in medical sta	

_____ DATE _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____