MEDICAL HISTORY

i aliento Name	Patien	ts N	Van	ne:_
----------------	--------	------	-----	------

Date of Birth:_____

Other If yes, please explain: Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Drug Addiction Yes No Anaphylaxis Yes No Drug Addiction Yes No Anagina Yes No Easily Winded Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No High Blood Pressure Yes No Renumatic Fever Yes Artificial Joint Yes No Excessive Bleeding Yes No Hoppolycemia Yes No Slood Disease Yes No Frequent Darpha Yes No Frequent Diarnhea Yes No Blood Transfusion Yes No Excessive Thirst Yes No Hingh Problem Yes No Frequent Dairnhea Yes No Blood Transfusion Yes	
Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actonel or any yes No Are you on a special diet? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No "Women: Are you Pregnant/Trying to get pregnant? Yes No Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulf Other If yes, please explain:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No Are you on a special diet? Yes No Do you use controlled substances? Yes No Women: Are you Do you use controlled substances? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulf Other If yes, please explain:	
Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Are you allergic to any of the following?	
Do you use tobacco? Yes No Do you use controlled substances? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following?	
Do you use controlled substances? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Are you allergic to any of the following?	
Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following?	
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following?	
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulf Other If yes, please explain:	
Other If yes, please explain: Do you have, or have you had, any of the following? AlDS/HIV Positive Yes No AlDS/HIV Positive Yes No Diabetes Yes No Diabetes Yes No Anaphylaxis Yes No Drug Addiction Yes No Anaphylaxis Yes No Anapina Yes No Antriticial Heart Valve Yes No Artificial Joint Yes No Astmaa Yes No Blood Disease Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Frequent Headaches Yes No Broating Problem Yes No Frequent Headaches Yes No Corrisona Genital Herpes Yes No Recent Weight Loss Yes No Reneal Dialysis Yes Antificial Joint Yes No Excessive Thirst Yes No	
Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Anemia Yes No Angina Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Artificial Joint Yes No Frequent Cough Yes No Blood Transfusion Yes No Blood Transfusion Yes No Brequent Cough Yes No Frequent Diarrhea Yes No Breathing Problem Yes No Genital Herpes Yes No Genital Herpes Yes No Frequent Headaches Yes No Frequent Headaches Yes No Blood Disease Yes No Genital Herpes No Leukemia Yes No	a drugs
Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Artificial Joint Yes No Frequent Cough Yes No Frequent Cough Yes No Blood Transfusion Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Frequent Headaches Yes No Brouse Easily Yes No Genital Herpes Yes No Frequent Headaches Yes No Blood Disease Yes No Blood Disease Yes No Genital Herpes<	
AIDS/HIV PositiveYesNoCortisone MedicineYesNoHemophiliaYesNoRadiation TreatmentsYesAlzheimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRecent Weight LossYesAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoReal DialysisYesAnemiaYesNoEasily WindedYesNoHerpesYesNoReumatic FeverYesAnginaYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoReumatic FeverYesArtificial Heart ValveYesNoExcessive BleedingYesNoHives or RashYesNoSinuslesYesAsthmaYesNoFainting Spells/DizzinessYesNoHregular HeartbeatYesNoSinus TroubleYesBlood DiseaseYesNoFrequent DiarrheaYesNoLiver DiseaseYesNoSinus TroubleYesBlood TransfusionYesNoFrequent HeadachesYesNoLiver DiseaseYesNoStrokeYesBruise EasilyYesNoGaucomaYesNoLiver DiseaseYesNoStrokeYesBruise EasilyYesNoGlaucomaYesNoLung DiseaseYesNoStrokeYesBruise EasilyYesNoGlaucoma <t< th=""><th></th></t<>	
AIDS/HIV PositiveYesNoCortisone MedicineYesNoHemophiliaYesNoRadiation TreatmentsNoAlzheimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRecent Weight LossNoAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoReal DialysisNoAnemiaYesNoEasily WindedYesNoHerpesYesNoReumatic FeverNoAnginaYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoReumatic FeverNoArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoScarlet FeverNoArthritis/GoutYesNoExcessive ThirstYesNoHypoglycemiaYesNoSinus TroubleNoArthritis/GoutYesNoFrequent CoughYesNoFrequent DiarrheaYesNoSinus TroubleNoBlood DiseaseYesNoFrequent HeadachesYesNoLiver DiseaseYesNoStrokeNoBlood TransfusionYesNoGenital HerpesYesNoLiver DiseaseYesNoStrokeNoBruise EasilyYesNoGlaucomaYesNoLung DiseaseYesNoStrokeNoBruise EasilyYesNoGlaucomaYes <t< th=""><th></th></t<>	
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 A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Easily Winded Yes No Herpes Yes No Renal Dialysis Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatic Fever Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Scarlet Fever Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sinus Trouble Yes No Asthma Yes No Frequent Diarrhea Yes No Leukemia Yes No Sinus Trouble Yes No Blood Disease <td< th=""><th></th></td<>	
AnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRenal DialysisYesAnemiaYesNoEasily WindedYesNoHerpesYesNoRheumatic FeverYesAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumatic FeverYesAnthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoScarlet FeverYesArtificial Heart ValveYesNoExcessive BleedingYesNoHives or RashYesNoSickle Cell DiseaseYesArtificial JointYesNoExcessive ThirstYesNoHregular HeartbeatYesNoSinus TroubleYesAsthmaYesNoFrequent CoughYesNoLeukemiaYesNoSinus TroubleYesBlood DiseaseYesNoFrequent DiarrheaYesNoLeukemiaYesNoStomach/Intestinal DiseaseYesBlood TransfusionYesNoGenital HerpesYesNoLiver DiseaseYesNoStrokeYesBruise EasilyYesNoGlaucomaYesNoLung DiseaseYesNoThyroid Disease	Yes ()
AnemiaYesNoEasily WindedYesNoHerpesYesNoRheumatic FeverYesAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumatic FeverYesAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumaticsArthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoScarlet FeverYesArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoSickle Cell DiseaseYesArthritis/GoutYesNoExcessive ThirstYesNoHypoglycemiaYesNoSinus TroubleYesAsthmaYesNoFrequent CoughYesNoIrregular HeartbeatYesNoSinus TroubleYesBlood DiseaseYesNoFrequent DiarrheaYesNoLeukemiaYesNoStomach/Intestinal DiseaseYesBlood TransfusionYesNoGenital HerpesYesNoLiver DiseaseYesNoStrokeYesBruise EasilyYesNoGlaucomaYesNoLung DiseaseYesNoThyroid Disease	
AnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumatismYesArthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoScarlet FeverYesArthritis/GoutYesNoExcessive BleedingYesNoHigh CholesterolYesNoScarlet FeverYesArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoSickle Cell DiseaseArthritis/GoutYesNoExcessive ThirstYesNoHypoglycemiaYesNoSickle Cell DiseaseArthritis/GoutYesNoFainting Spells/DizzinessYesNoIrregular HeartbeatYesNoSinus TroubleAsthmaYesNoFrequent CoughYesNoKidney ProblemsYesNoSpina BifidaYesBlood DiseaseYesNoFrequent HeadachesYesNoLeukemiaYesNoStomach/Intestinal DiseaseYesBlood TransfusionYesNoGenital HerpesYesNoLow Blood PressureYesNoStrokeYesBruise EasilyYesNoGlaucomaYesNoLung DiseaseYesNoThyroid DiseaseYes	Yes () ∣ Yes () ∣
Arthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh CholesterolYesNoScarlet FeverArthritis/GoutYesNoExcessive BleedingYesNoHigh CholesterolYesNoScarlet FeverYesArthritis/GuitYesNoExcessive BleedingYesNoHives or RashYesNoScarlet FeverArthritis/GuitYesNoExcessive ThirstYesNoHives or RashYesNoSickle Cell DiseaseArthmaYesNoFainting Spells/DizzinessYesNoIrregular HeartbeatYesNoSinus TroubleBlood DiseaseYesNoFrequent CoughYesNoKidney ProblemsYesNoSpina BifidaBlood TransfusionYesNoFrequent HeadachesYesNoLeukemiaYesNoStomach/Intestinal DiseaseBruise EasilyYesNoGenital HerpesYesNoLow Blood PressureYesNoSwelling of LimbsYesCancerYesNoGlaucomaYesNoLung DiseaseYesNoThyroid DiseaseYes	Yes ()
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes Artificial Joint Yes No Excessive Thirst Yes No Hives or Rash Yes No Shingles Yes No Asthma Yes No Fainting Spells/Dizziness Yes No Hives or Rash Yes No Sickle Cell Disease Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Breathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes No Stroke Yes No Bruise Easily Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes	Yes ()
Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Breathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes No Stroke Yes No Bruise Easily Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No	Yes
Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Sinus Trouble Yes No Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Breathing Problem Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Yes Yes Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes Yes <th>Yes</th>	Yes
Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes Blood Disease Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes Breathing Problem Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes	Yes
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Breathing Problem Yes No Frequent Headaches Yes No Liver Disease Yes No Stomach/Intestinal Disease Yes No Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes	Yes
Breathing Problem Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No	Yes
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No	Yes
Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease	Yes
	Yes
	Yes
	Yes
Shest Pains Tes Vito Heart Attack/Paintie Tes Vito Osteoporosis Tes Vito Tumore or Growthe	Yes
	Yes 🔘
Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Venereal Disease	Yes 🔘
Convulsions Ves No Heart Trouble/Disease Yes No Psychiatric Care Yes No Yellow Jaundice	Yes 🔵
Have you ever had any serious illness not listed above? O Yes O No	
Comments:	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE ______