MEDICAL HISTORY

Estimated Delivery Date: Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other Yes No If yes, please explain: Do you have, or have you had, any of the following? AlDs/HiV Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes No Renal Dialysis Yes No Alzheimer's Disease Yes No Diabetes Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No Anaphylaxis Yes No Easily Winded Yes No Herpes Yes No Scarlet Fever Yes No Angina Yes No Emphysema Yes No Herpes Yes No Scarlet Fever Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sickle Cell Disease Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sinus Trouble Yes No Asthma Yes No Frequent Cough Yes No Leukemia Yes No Stroke Yes No Blood Disease Yes No Frequent Diarrhea Yes No Leukemia Yes No Stroke Yes No Breathing Problem Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Somach/Intestinal Disease Yes No Breathing Problem Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Stroke Yes No Stroke Yes No Breathing Problem Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Breathing Problem Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Pain In Jay Joints Yes No Tumors or Growths Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Parinting Yes No Paychiatric Care Yes No Disease Yes No Disease Yes No Heart Attack/Failure Yes No Radiation Treatments Yes No Disease Yes No Disease Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Pasch Weight Loss Yes No Yellow Jaundice Yes No Pasch Weight Loss Yes No Yellow Jaundice Yes No Pasch Weight Loss Yes No Yellow Jaundice Yes No Pasch Weight Loss Yes No Yellow Jaundice Yes No Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yellow Jau	have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you taking any medications, pills, or drugs? Have you ever been hospitalized or had a major operation? Are you under a physician's care now? Are you under a physician's care now? Are you under a physician's care now? Have you ever had a serious head or neck injury? Yes No If yes, please explain: Do you taken, or have you taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No If yes, please explain: Do you use controlled substances? Yes No If yes, please explain: Do you use controlled substances? Yes No If yes, please explain: Do you need to pre-medicate? Yes	have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you taking any medications, pills, or drugs? Are you taking any medications, pills, or drugs? Are you take a read you have a major operation? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Are you utake, or have you taken, Phen-Fen or Redux? Do you take, or have you taken, Phen-Fen or Redux? Yes No Do you have any artificial or prosthetic joints? Do you use tobacco? Yes No Do you use controlled substances? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Do you late, or have you frequent? Women: Are you Pregnant? Yes No Trying to get pregnant? Yes No Taking birth control? Yes No Nursing? Yes Estimated Delivery Date: Are you allergic to any of the following? Albshirl Postitive Yes No If yes, please explain: Do you have, or have you had, any of the following? Albshirl Postitive Yes No Dispose Yes No Prequent Planta Yes		P	PATIENT	NAME	i						Birth Da	te					
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Do you have any artificial or prosthetic joints? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Women: Are you Pregnant? Yes No Trying to get pregnant? Yes No Taking birth control? Yes No Nursing? Yes No Estimated Delivery Date: Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other Yes No If yes, please explain: Do you have, or have you had, any of the following? 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