MEDICAL HISTORY

PATIENT NAME		Birth Date		
= -	•	-		dy. Health problems that you may reive. Thank you for answering the
ave you ever been hospita Have you ever had Are you taking an Do you take, or have y Do y	under a physician's care now? (lized or had a major operation? (a serious head or neck injury? (ny medications, pills, or drugs? (ou taken, Phen-Fen or Redux? (Are you on a special diet? (Do you use tobacco? (ou use controlled substances? (Yes No If yes, plead Yes No If yes, plead Yes No If yes, plead Yes No Yes No Yes No		
Are you allergic to any of Aspirin Peni Other If yes, please	cillin Codeine	Acrylic Metal	Latex Local A	nesthetics
AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy	etherword on a cathour of than brusht manner i settempolem brussendered before decembed assetting decides and the cathour and	Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Yes No If yes, pleas	a i in . I i i i k d'ara beforede de	Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice
dangerous to my (or patie	edge, the questions on this form lent's) health. It is my responsibil	ity to inform the dental offic	e of any changes in medical s	_