## **MEDICAL HISTORY**

PATIENT NAME				Birth Date			
				rour mouth is a part of your e			
Are you under a physician's care now? Yes No Have you ever been hospitalized or had a major operation? Yes No Have you ever had a serious head or neck injury? Yes No Are you taking any medications, pills, or drugs? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No				If yes, please explain:  If yes, please explain:  If yes, please explain:  If yes, please explain:			
─Women: Are you── Pregnant/Trying to ge	et pregnant?	Yes O No Taking	oral contrace	otives? O Yes O No	Nursing? O Y	′es	
Are you allergic to ar Aspirin Other If yes, pl	Penicillin [		erylic	Metal Latex	Local Anesth	netics	
	Yes       No         Ier       Yes       No         Yes       No         Yes       No         No       Yes       No         No       Yes       No         No       Yes       No	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker	<ul> <li>Yes ○ No</li> <li>Yes ○ No</li> <li>Yes ○ No</li> <li>Yes ○ No</li> <li>O Yes ○ No</li> </ul>	Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss	Yes ○ No         Rheu           Yes ○ No         Rheu           Yes ○ No         Scarl           Yes ○ No         Sickle           Yes ○ No         Sinus           Yes ○ No         Stom           Yes ○ No         Strok           Yes ○ No         Swell           Yes ○ No         Thyro           Yes ○ No         Tonsi           Yes ○ No         Ulcer           Yes ○ No         Ulcer           Yes ○ No         Yene           Yes ○ No         Yene           Yes ○ No         Yene           Yes ○ No         Yellor	e Cell Disease s Trouble a Bifida ach/Intestinal Disease e ling of Limbs oid Disease illitis rculosis ors or Growths	Yes No
Comments:							
	-			y answered. I understand the tal office of any changes in r		ect information can b	oe
SIGNATURE OF PA	ATIENT, PARENT	, or GUARDIAN			DAT	ΓΕ	