## **MEDICAL HISTORY**

PATIENT NAME		Birth Date		
Although dental personnel primarily tr have, or medication that you may be following questions.				
Have you ever been hospitalized or had Have you ever had a serious Are you taking any medicat Do you take, or have you taken, F lave you ever taken Fosamax, Boniva, medications containir Are you	head or neck injury? Yes No tions, pills, or drugs? Yes No Phen-Fen or Redux? Yes No Actonel or any other	If yes, please explain:  If yes, please explain:  If yes, please explain:		
Women: Are you Pregnant/Trying to get pregnant?  Are you allergic to any of the following	Yes No Taking oral contract	reptives? O Yes O No	Nursing?  Yes No	
Aspirin Penicillin  Other If yes, please explain:	Codeine Local Anesthe	tics Acrylic [	Metal Latex	Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive Yes No AIDS/HIV Positive AIDS/HIV Positive Yes No AIDS/HIV Positive AIDS/H	Cortisone Medicine Yes No Diabetes Yes No Prug Addiction Yes No Pr	No Osteoporosis Yes No Pain in Jaw Joints Yes No Parathyroid Disease Yes	Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Turnors or Growths	Yes No.
Comments:				
To the best of my knowledge, the quedangerous to my (or patient's) health.				can be
SIGNATURE OF PATIENT, PARENT,		ental office of any changes in m		