## MEDICAL HISTORY

Birth Date:

Are you under a physician's care now? Yes No If yes, please explain:  Have you ever had a serious head or neck injury? Yes No If yes, please explain:  Are you taking any medications, pills, or drugs? Yes No If yes, please explain:  Do you take, or have you taken, Phen-Fen or Redux? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you use controlled substances? Yes No Occare and you go you have, or have you had, any of the following?  Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  Other If yes, please explain:  Do you have, or have you had, any of the following? No Occare with your you go you have, or have you had, any of the following? No Occare with your you have, or have you had, any of the following? No Occare with your you have, or have you had, any of the following? No Occare with your you go you you you you you you you you you yo	- 1
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Are you taking any medications, pills, or drugs? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Women: Are you Pregnant/Tying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:  Do you have, or have you had, any of the following? Alspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:  Do you have, or have you had, any of the following? Alspirin Penicillin Codeine Yes No Hepatits A Yes No Renal Dialysis Namphylaxis Yes No Drug Addiction Yes No Hepatits Bor C Yes No Renumatic Fever Anemia Yes No Emphysema Yes No High Blood Pressure Yes No Shingles Antificial Heart Valve Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sinus Trouble Staffind Johnt Yes No Excessive Bleeding Yes No Hepatits Yes No Sinus Trouble Staffind Johnt Yes No Frequent Cough Yes No Leukemia Yes No Sinus Trouble Staffind Johnt Yes No Frequent Cough Yes No Leukemia Yes No Sinus Trouble Stroke Beality Yes No Frequent Cough Yes No Leukemia Yes No Sinus Trouble Stroke Beality Yes No Genial Herpes Yes No Leukemia Yes No Sinus Trouble Stroke Beality Yes No Hepatits Yes No Leukemia Yes No Sinus Trouble Stroke Beality Yes No Hepatity Alve Problems Yes No Sinus Trouble Stroke Beality Yes No Hepatity Alve Problems Yes No Sinus Trouble Stroke Beality Yes No Hepatity Alve Problems Yes No Tumors or Growths United Disease Yes No Heart Murriur Yes No Parathyroid Disease Yes No Heart Murriur Yes No Parathyroid Disease Yes No Heart Murriur Yes No Recent Weight Loss Yes No Vellow Jaundice  Have you ever had any serious illness not listed above? Yes No If yes, please explain:	
Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use tobacco? 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 Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:  Do you have, or have you had, any of the following? IDS/HIV Positive Yes No Cortisone Medicine Yes No Hepatitis B or C Yes No Renumatic Fever Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renumatism Yes No Emphysema Yes No Hepatitis B or C Yes No Single Strifficial Heart Valve Yes No Emphysema Yes No Hiph Blood Pressure Yes No Single Single Strifficial Heart Valve Yes No Emphysema Yes No Hiph Blood Pressure Yes No Single Single Single Single Single Yes No Hepatitis Pressore No Single Single Single Single Yes No Hepatitis Pressure Yes No Hiph Blood Pressure Yes No Single Single Single Single Single Single Yes No Hiph Blood Pressure Yes No Single Single Single Yes No Hiph Blood Pressure Yes No Single Single Single Yes No Hiph Blood Pressure Yes No Single Single Single Yes No Hiph Blood Pressure Yes No Single Single Single Yes No Hiph Blood Pressure Yes No Hiph Blood Pressure Yes No Single Single Single Yes No Hiph Blood Pressure Yes No Single Single Single Yes No Hiph Blood Pressure Yes No Single Single Problem Yes No Excessive Bleeding Yes No Hiph Blood Pressure Yes No Single Single Problem Yes No Excessive Thirst Yes No Hiph Blood Pressure Yes No Single Single Problem Yes No Single Problem Yes No Heart Hardore Yes No Heart Hearthea Yes No Stroke No Stroke No Stroke No Stroke No Stroke No Heart Hardore Yes No Hea	
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Have you ever had any serious illness not listed above? Ves No If yes, please explain:	Yes N
Comments:	
Comments:	
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect informa dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	ion can be
Langerous to my (or patients) health. It is my responsibility to inform the defital office of any changes in medical status.	
SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATEDATE	