MEDICAL HISTORY

PATIENT NAME		Birth Date	
			e body. Health problems that you may I receive. Thank you for answering the
Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medication Do you take, or have you taken, Pl Have you ever taken Fosamax, Bou other medications containing	ead or neck injury? Yes No ons, pills, or drugs? Yes No nen-Fen or Redux? Yes No niva, Actonel or any	o If yes, please explain: o If yes, please explain: o If yes, please explain:	
Do	you use tobacco? Yes No rolled substances? Yes No)	g? () Yes () No
Are you allergic to any of the following Aspirin Penicillin		-	
Other If yes, please explain:	Codelile Local Allestine	etics Actylic INEL	Latex Suita drugs
AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Convulsions Yes No Convulsions Yes No Convulsions Illness	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 Pacemaker Heart Trouble/Disease Yes Yes Yes Yes Yes Yes Yes	No Hepatitis A Yes No No Hepatitis B or C Yes No No Herpes Yes No No High Blood Pressure Yes No No High Cholesterol Yes No No Hives or Rash Yes No No Hregular Heartbeat Yes No No Hregular Heartbeat Yes No No Leukemia Yes No Leukemia Yes No Low Blood Pressure Yes No No Lung Disease Yes No Mo Mitral Valve Prolapse Yes No No No Steoporosis Yes No No Parin in Jaw Joints Yes No No Parathyroid Disease Yes No No No Psychiatric Care Yes No No No No Parathyroid Disease Yes No No No Psychiatric Care Yes No	Recent Weight Loss
Comments:			
dangerous to my (or patient's) health	. It is my responsibility to inform th	urately answered. I understand that posterior of any changes in medi	cal status.
SIGNATURE OF PATIENT, PARENT	, or GUARDIAN		DATE