MEDICAL HISTORY

| PATIENT NAME | | Birth Date | |
|--|-----------------------------|--|---|
| Although dental personnel primarily trea have, or medication that you may be ta following questions. | - | | |
| Have you ever been hospitalized or had Have you ever had a serious lare you taking any medication of the you take, or have you taken, Fare you | | If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain: | |
| Do you use con-Women: Are you | trolled substances? Yes No | | |
| Pregnant/Trying to get pregnant? —Are you allergic to any of the following? — Aspirin — Penicillin — Other If yes, please explain: | | | ng? Yes No |
| | Diabetes | Hepatitis A Yes N Hepatitis B or C Yes N Herpes Yes N High Blood Pressure Yes N Hives or Rash Yes N Hypoglycemia Yes N Irregular Heartbeat Yes N Leukemia Yes N Leukemia Yes N Low Blood Pressure Yes N Lung Disease Yes N Mitral Valve Prolapse Yes N Pain in Jaw Joints Yes N Parathyroid Disease Yes N Parathyroid Disease Yes N Psychiatric Care Yes N Radiation Treatments Yes N Recent Weight Loss Yes N | Rheumatic Fever Yes No Rheumatism Yes No Rheumatism Yes No Scarlet Fever Yes No Scarlet Fever Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stowelling of Limbs Yes No Thyroid Disease Yes No Tuberculosis Yes No Ulcers Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Vello Vellow Jaundice Yes No |
| Comments: | | | |
| To the best of my knowledge, the quest dangerous to my (or patient's) health. | | | |
| SIGNATURE OF PATIENT, PARENT | or GUARDIAN | | DATE |