MEDICAL HISTORY

PATIENT NAME		Birth Date		
				dy. Health problems that you may eive. Thank you for answering the
Ave you ever been hospital Have you ever had Are you taking ar Do you take, or have you Have you ever taken Fo other medications	by medications, pills, or drugs? bu taken, Phen-Fen or Redux? samax, Boniva, Actonel or any containing bisphosphonates? Are you on a special diet? Do you use tobacco? bu use controlled substances?	Yes No If yes, plea Yes No If yes, plea Yes No If yes, plea Yes No Yes No Yes No Yes No Yes No	se explain: se explain: se explain:	gnant? Nursing?
Asorin Peniatin		Carylic Metal	Litex Local Anesthetics	Sulfa Drugs
AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy	had, any of the following? Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea	Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Yes No If yes, please	Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments 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 Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice
	dge, the questions on this form			ing incorrect information can be tatus.
200	T, PARENT, or GUARDIAN			DATE