MEDICAL HISTORY

O'ther If yes, please explain: O you have, or have you had, any of the following? AIDS/HIV Positive	PATIENT NAME						_ Birth Date			
Have you ever had a region peration? Yes No No If yes, please explain:	or medication that you i	may be taking,	could have an import						olems that you	ı may have,
Women: Are you Pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O	Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Are you on a special diet? Do you use tobacco? Do you use controlled substances?				O No O No O No O No O No O No O No	If yes, please explai If yes, please explai If yes, please explai	n: n: n: n:			
Aspirin Penicillin Codeline Acrylic Metal Latex Local Anesthetics										
AlDSHIV Positive	☐ Aspirin ☐ Pe	enicillin [_	☐ Acrylic		☐ Metal	□ Latex	☐ Local A	Anesthetics	
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. By my signature below, I hereby consent to the examination and dental treatment. I understand dentistry is not an exact science and the results of any treatments vary from patient to patient. I understand occasionally, additional treatment may be required. I agree that cash payment or credit arrangements for the estimated un-insured portion of treatment will be made at the time of treatment and I agree that the estimate given to me may not be the final or exact amount that I will owe for treatment.	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 Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions	Yes \ No \ Yes \ Yes \ No \ Yes \ Yes \ No \ Yes \ Y	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizzine Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease	○ Ye ○ Ye	S	Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss	Yes Yes	No Rheumatic Feve Rheumatism Scarlet Fever Shingles Sickle Cell Diseason Sinus Trouble Spina Bifida Stomach/Intestin Stroke Swelling of Limb Thyroid Disease Tonsillitis Tuberculosis Tumors or Grow Ulcers Venereal Diseas Yellow Jaundice No	r (() () () () () () () () () () () () ()	Yes ONO
SIGNATURE OF PATIENT, PARENT, or GUARDIANDATE	to my (or patient's) healt examination and dental occasionally, additional t made at the time of treat	h. It is my resp treatment. I und treatment may tment and I agr	consibility to inform the derstand dentistry is a be required. I agree to ee that the estimate of the control o	e dental o not an exa hat cash p given to m	ffice of a ct science ayment e may n	any changes in medic ce and the results of or credit arrangemer ot be the final or exa	cal status. By any treatmer nts for the es ct amount th	r my signature belo nts vary from patien timated un-insured at I will owe for trea	w, I hereby co t to patient. I u portion of trea tment.	nsent to the understand atment will b
	SIGNATURE OF PATIE	NT, PARENT,	or GUARDIAN					DATE _		

DOCTOR SIGNATURE ______ DATE _____