## **MEDICAL HISTORY**

PATIENT NAME		Birth Date		
Although dental personnel primarily trea have, or medication that you may be ta following questions.				
lave you ever been hospitalized or had a Have you ever had a serious hea Are you taking any medication Do you take, or have you taken, Phe Have you ever taken Fosamax, Bonio other medications containing b	ad or neck injury? Yes No s, pills, or drugs? Yes No en-Fen or Redux? Yes No va, Actonel or any	If yes, please explain:  If yes, please explain:  If yes, please explain:  If yes, please explain:		
Do you use contro Women: Are you	you use tobacco? Yes No olled substances? Yes No	Northwest O Vac O No. Northwest	· · · · · · · · · · · · · · · · · · ·	
Pregnant/Trying to get pregnant? Ye		eptives? Yes No Nursir	ng? () Yes () No	
Are you allergic to any of the following?  Aspirin Penicillin	Codeine Local Anestheti	cs Acrylic Me	tal Latex	Sulfa drugs
Other If yes, please explain:				
Alzheimer's Disease         Yes         No           Anaphylaxis         Yes         No           Anemia         Yes         No           Angina         Yes         No           Arthritis/Gout         Yes         No           Artificial Heart Valve         Yes         No           Artificial Joint         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           Chest Pains         Yes         No           Cold Sores/Fever Blisters         Yes         No           Congenital Heart Disorder         Yes         No	Cortisone Medicine Yes No. Diabetes Yes No. Drug Addiction Yes No. Easily Winded Yes No. Emphysema Yes No. Excessive Bleeding Yes No. Excessive Thirst Yes No. Frainting Spells/Dizziness Yes No. Frequent Cough Yes No. Frequent Diarrhea Yes No. Frequent Headaches Yes No. Genital Herpes Yes No. Glaucoma Yes No. Hay Fever Yes No. Hay Fever Yes No. Heart Murmur Yes No. Heart Trouble/Disease Yes No.	Hepatitis A	Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Dis Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Veneral Disease	Yes
Comments:				
To the best of my knowledge, the quest dangerous to my (or patient's) health.				ation can be
SIGNATURE OF PATIENT, PARENT, (	or GUARDIAN		DATE	