MEDICAL HISTORY

Have you ever been Have you ev Are you ta	hat you m re you und hospitaliz ver had a king any	der a p zed or l serious	taking, could have ar hysician's care now? had a major operatior	importan Yes	t interr	elationship	with the denti	stry you	ı will re	ceive. Thank y	you for ans	-	-
Have you ever been Have you ev Are you ta	hospitaliz ver had a king any	zed or l serious	had a major operation				se explain:						
	Are you under a physician's care now? 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?					If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:							-
	-		ntrolled substances? eed to pre-medicate?	Yes Yes	No No	If yes, pleas	se explain:						
Women: Are you Pro	-			es	No	Taking o	oral contracep	otives?	Yes	No	Nursing?	Yes	No
-	Penicillin	011011111	Codeine	Acrylic		Metal	Latex		Local /	Anesthetics			
Other If yes, ple	ase expla	ain:		,									
Do you have, or have	vou had.	any of	f the following?										
IDS/HIV Positive	Yes	No No	Cortisone Medicine	Yes	No	Hemoph	ilia	Yes	No	Renal Dialysis		Yes	N
zheimer's Disease	Yes	No	Diabetes	Yes				Yes	No	Rheumatic Fev	er	Yes	N
naphylaxis	Yes	No	Drug Addiction	Yes		•		Yes	No	Rheumatism		Yes	N
nemia	Yes	No	Easily Winded	Yes		•		Yes	No	Scarlet Fever		Yes	Ν
ngina	Yes	No	Emphysema	Yes		•	od Pressure	Yes	No	Shingles		Yes	Ν
rthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	•		Yes	No	Sickle Cell Dise	ease	Yes	Ν
rtificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypogly	cemia	Yes	No	Sinus Trouble		Yes	Ν
rtificial Joint	Yes	No	Excessive Thirst	Yes	No		Heartbeat	Yes	No	Spina Bifida		Yes	Ν
sthma	Yes	No	Fainting Spells/Dizzin	ess Yes	No	Kidney F	roblems	Yes	No	Stomach/Intest	inal Disease	Yes	N
lood Disease	Yes	No	Frequent Cough	Yes	No	Leukemi	а	Yes	No	Stroke		Yes	Ν
lood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Dis	ease	Yes	No	Swelling of Lim	ıbs	Yes	Ν
reathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Bloc	od Pressure	Yes	No	Thyroid Diseas	e	Yes	Ν
ruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Dis	ease	Yes	No	Tonsillitis		Yes	Ν
ancer	Yes	No	Glaucoma	Yes	No	Mitral Va	lve Prolapse	Yes	No	Tuberculosis		Yes	Ν
hemotherapy	Yes	No	Hay Fever	Yes	No	Pain in J	aw Joints	Yes	No	Tumors or Gro	wths	Yes	Ν
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyr	oid Disease	Yes	No	Ulcers		Yes	Ν
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiat	ric Care	Yes	No	Venereal Disea	ase	Yes	Ν
-	r Yes Yes	No No	Heart Pace Maker Heart Trouble/Disease	Yes e Yes			n Treatments Veight Loss	Yes Yes	No No	Yellow Jaundic	е	Yes	N
Have you ever had an	ny serious	illness	s not listed above?	Yes	No	If yes, p	lease explain	:					
Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorde Convulsions Have you ever had an	Yes Yes r Yes Yes	No No No No	Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease	Yes Yes Yes e Yes	No No No No	Parathyr Psychiat Radiation Recent V	oid Disease ric Care n Treatments Veight Loss lease explain	Yes Yes Yes Yes	No No No No	Ulcers Venereal Disea	ase ee	Yes Yes Yes	