MEDICAL HISTORY

Although dental personnel primarily tre have, or medication that you may be ta following questions.			
Have 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, Boni other medications containing t	a major operation? Yes No ad or neck injury? Yes No ns, pills, or drugs? Yes No en-Fen or Redux? Yes No va, Actonel or any Yes No bisphosphonates?	If yes, please explain: If yes, please explain: If yes, please explain:	
Doy	on a special diet? () Yes () No you use tobacco? () Yes () No oblied substances? () Yes () No		
Pregnant/Trying to get pregnant? Yes	es No Taking oral contrace	eptives? Yes No Nursing	g? O Yes O No
Are you allergic to any of the following? Aspirin Penicillin Other If yes, please explain:	Codeine Local Anestheti	cs Acrylic Meta	al Latex Sulfa drugs
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 Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Chest Pains Yes No Congenital Heart Disorder Yes No Congenital Heart Disorder Yes No	Cortisone Medicine Yes Note Diabetes Yes Note Diabetes Yes Note Drug Addiction Yes Note Drug Addiction Yes Note Easily Winded Yes Note Emphysema Yes Note Drug Addiction Yes N	Hepatitis A	Recent Weight Loss
Comments:			
To the best of my knowledge, the quest dangerous to my (or patient's) health.			
SIGNATURE OF PATIENT, PARENT,	or GUARDIAN		DATE