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## Medical History Form

Na	ame:	Date:			
Date of birth:		Sex: Male/ Female Height:	Sex: Male/ Female Height:Weight		
		g questions, please circle yes or no, whichever applies. Your answers red confidential.	are for our reco	ords only, and	
1.	Are you in g	ood health?	Yes	No	
		peen any changes in your health in the past year?	Yes	No	
		ical exam was:			
4.	Are you now	under the care of a physician?	Yes	No	
	Fo	r what condition?			
5.	The name a	nd address of my physician:			
6.	-	ave you had any of the following diseases or problems?			
		Damaged or artificial heart valves or heart murmur		No	
		Rheumatic heart disease	Yes	No	
	C.	Heart trouble, heart attack, angina, high blood pressure, stroke,	V	Nie	
		arteriosclerosis, or any other heart condition		No	
		1. Chest pain upon exertion	Yes	No	
		Shortness of breath after mild exercise		No	
	-1	3. Do your ankles swell	Yes	No	
		Allergies		No	
	_		Yes	No	
	f.	Asthma or hay fever		No	
		Fainting spells or seizures	Yes	No	
	h.	Diabetes		No	
	I.	Hepatitis, jaundice or liver disease	Yes	No	
	J.	Frequent or recurring mouth sores		No	
		Thyroid problems	Yes	No	
	I.	Respiratory problems, emphysema, bronchitis, etc.		No	
		Arthritis or painful, swollen joints including jaw joint (TMJ)	Yes	No	
		Stomach ulcer or hyperactivity		No No	
		Kidney trouble	Yes	No	
	p.	Persistent cough or cough that produces blood		No No	
	q.	Tuberculosis	Yes	No	
	r.	Persistent swollen neck glands		No	
	_	Low blood pressure	Yes	No	
	t.	Epilepsy or neurological disorder		No	
		Are you taking vitamins or homeopathic remedies	Yes	No	
				No	
_		A disease, drug or transplant that depresses your immune system	Yes	No	
	W. A disease, drug or transplant that depresses your immune system  Yes  No  Are you wearing contact lenses?  Are you wearing removable dental appliances (bridge, partial, etc.)?  Yes  No				
9.	nave you ev	er had treatment for a tumor or growth?	Yes	No	

a Local anesthetics.  b. Penicillitin or antibiotics  c. Sulfa drugs. d. Barbituates or sleeping pills e. Aspirim.  Yes No e. Aspirim.  9 Codene or other narcotics. 9 Ves No 1 Lodine 9 Codene or other narcotics. 9 Ves No h. Latex (exam gloves) 10 Cher. Please List. 11 Have you had any serious trouble associated with previous dental treatment? 12 No 12 Are you taking or have you ever taken Bisphosphonatas (Fosamax, Actonel, for Ves No ostseportosis, Chemotherapy for multiple myeloma, etc.)? 1 Any serious litness, operation or hospitalization in the last 5 years? 1 No 1 Have you had abnormab libeding? 1 No 1 Have you had abnormab libeding? 1 No 1 Have you had abnormab libeding? 1 No 1 Have you any blood disorder such as anemian? 2 No 1 Do you have any blood disorder such as anemian? 3 No 1 Do you shore, wake up multiple times at night, feel unrested in the morning or have sleep apnea? 4 No 1	Continuation of Medical History Form					
b. Penicillin or antibiotics c. Sulfa drugs	10. Are you allergic to or have you had a reaction to:					
c. Sulfa drugs						
d. Barbituates or sleeping pills e. Aspirin						
e. Aspirin						
f. lodine g. Codeine or other narcotics						
g. Codeline or other narcotics	·					
n. Latex (exam glowes) i. Other: Please List: Yes No l. Have you had any serious trouble associated with previous dental treatment? Yes No l. Have you had any serious trouble associated with previous dental treatment? Yes No osteoporosis, chemotherapy for multiple myeloma, acto? Any serious illness, operation or hospitalization in the last 5 years? Yes No l. Have you had abnormal bleeding? Yes No a. Have you had abnormal bleeding? Yes No l. Have you had abnormal bleeding? Yes No l. Have you had abnormal bleeding? Yes No l. Do you have any blood disorder such as anemia? Yes No l. Do you have nave wake up multiple times at night, feel unrested in the morning or have sleep apnea? Yes No l. Do you wish to talk with doctor privately about anything? Yes No l. Are you taking any prescription or non-prescription medications? Yes No l. Are you taking any prescription or non-prescription medications? Yes No l. For you have any other condition or disease the doctor should know about? Yes No lf so, please list J. Ob you have any other condition or disease the doctor should know about? Yes No lf so, explain: Do you have problems associated with your menstrual cycle? Yes No l. Are you taking birth control pills? Yes No l. Are you taking birth control pills? Yes No l. Are you taking birth control pills?  wertify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to y satisfaction. I will not hold the oral surgeon, or any member of the staff responsible for any errors or omissions at may have been made in the completion of this form.  satient's signature: Date:    Date:   Date:   Date:						
i. Other: Please List: I. Have you had any serious trouble associated with previous dental treatment? Yes No object on the property of the provided of the pro	<u> </u>					
I. Have you had any serious trouble associated with previous dental treatment?  2. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for yes No osteoporosis, chemotherapy for multiple myeloma, etc.)?  3. Any serious illness, operation or hospitalization in the last 5 years?  3. Any serious illness, operation or hospitalization in the last 5 years?  4. No 1. Have you had abnormal bleeding?  5. Do you have any blood disorder such as anemia?  5. Do you have any blood disorder such as anemia?  6. Do you snore, wake up multiple times at riight, feel unrested in the morning or have sleep apnea?  7. Do you wish to talk with doctor privately about anything?  8. Are you taking any prescription or non-prescription medications?  9. Are you taking any prescription or oni-prescription medications?  9. Do you have any other condition or disease the doctor should know about?  9. Do you have problems associated with your menstrual cycle?  9. Are you pregnant or trying to become pregnant?  9. Are you taking birth control pills?  9. Do you have problems associated with your menstrual cycle?  9. Are you taking birth control pills?  9. Do you have problems associated with your menstrual cycle?  9. Yes No  1. Are you taking birth control pills?  1. Are you taking any prescription or one pregnant?  1. Are you taking birth control pills?  1. Ar	· · · · · · · · · · · · · · · · · · ·					
2. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for yes No osteoporosis, chemotherapy for multiple myeloma, etc.)? 3. Any serious illness, operation or hospitalization in the last 5 years?						
osteoporosis, chemotherapy for multiple myeloma, etc.)?  8. Any serious illness, operation or hospitalization in the last 5 years?						
1. Have you had abnormal bleeding?	osteoporosis, chemotherapy for multiple myeloma, etc.)?	162	NO			
a. Have you ever required a blood transfusion?  5. Do you have any blood disorder such as anemia?			No			
5. Do you have any blood disorder such as anemia?		Yes	No			
6. Do you snore, wake up multiple times at night, feel unrested in the morning or have sleep apnea? Yes No 7. Do you wish to talk with doctor privately about anything? Yes No 8. Are you taking any prescription or non-prescription medications? Yes No 1f so, please list Yes No 1f so, explain: Yes N						
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Do you have any other condition or disease the doctor should know about?  If so, explain:	Are you taking any prescription or non-prescription medications?  If so, please list	Yes	No			
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