PATIENT NAME _

Birth Date _____

MEDICAL HISTORY

	n that you may be	eat the area in and aro taking, could have an ir	the state of the s		The state of the s		
^	ro vou under a ph	/sician's care now?	Yes () No	If yes, please explain:			
			<u> </u>	If yes, please explain: If yes, please explain:			
			\simeq	If yes, please explain			
		ons, pills, or drugs?	~	If yes, please explain			
Have you ever ta	iken Fosamax, Bo	hen-Fen or Redux? () niva, Actonel or any g bisphosphonates?	Yes \(\) No				
	Are you	u on a special diet?	Yes O No				
		you use tobacco?	Yes O No				
	Do you use conf	trolled substances?	Yes No				
Women: Are you		Vac Ala Takina	oral contrace	otives? O Yes O N	o Nursing?		
Pregnant/Trying to	get pregnant?	Yes No Taking	oral contrace	otives? () Yes () N	o Nuising?	O les O NO	
Are you allergic to a							
Aspirin Other If yes, p	Penicillin lease explain:	Codeine Lo	ocal Anesthetic	S Acryli	c Metal	Latex	Sulfa drugs
D		SAL SALLANDO					
Do you have, or ha	0 0		○ Yes ○ N=	Usmankii:-	O Voc O N-	Dodintion Tracture - t-	O V O ::
AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	
Alzheimer's Disease	Yes No	Diabetes Drug Addiction	Yes No	Hepatitis A Hepatitis B or C		Recent Weight Loss Renal Dialysis	Yes No
Anaphylaxis Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	~ ~	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	O Yes O No	Hypoglycemia	Yes No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	Yes No	Fainting Spells/Dizziness	S Yes No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	Yes No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	
Blood Transfusion	Yes No	Frequent Diarrhea	○ Yes ○ No	Leukemia	Yes No	Stomach/Intestinal Dis	sease O Yes O No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	Yes No
Bruise Easily	○ Yes ○ No	Genital Herpes	Yes No	The state of the s	~ ~	Swelling of Limbs	Yes No
Cancer	○ Yes ○ No	Glaucoma	Yes No	The second secon	○ Yes ○ No	Thyroid Disease Tonsillitis	Yes No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No		× ×	Tuberculosis	Yes No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tumors or Growths	Yes No
Cold Sores/Fever Bliste	~ ~	Heart Murmur	Yes No		Yes No	Ulcers	Ŭ Yes Ŭ No
Congenital Heart Disor Convulsions	der Yes No	Heart Pacemaker Heart Trouble/Disease	Yes No		Yes No	Venereal Disease	Yes No
		ss not listed above?				Yellow Jaundice	◯ Yes ◯ No
Comments:		antonione (un montre de la companion de la comp					
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		estions on this form hand. It is my responsibility					nation can be
							-
SIGNATURE OF F	PATIENT, PARENT	Γ, or GUARDIAN				DATE	