MEDICAL HISTORY

PATIENT NAME		Birth Date	
	-		rire body. Health problems that you may will receive. Thank you for answering the
Have you ever been hospitalized or had Have you ever had a serious he Are you taking any medication Do you take, or have you taken, Ph Have you ever taken Fosamax, Bor other medications containing	ead or neck injury? Yes No ons, pills, or drugs? Yes No nen-Fen or Redux? Yes No niva, Actonel or any	o If yes, please explain: If yes, please explain: If yes, please explain:	
Do	you use tobacco? Yes No rolled substances? Yes No	0	ing? () Yes() No
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:			etal
Do you have, or have you had, any of AIDS/HIV Positive Yes No 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 Congenital Heart Disorder Yes No Conyulsions Yes No Convulsions Yes No Incorporation Yes No Convulsions Yes No Incorporation Yes No Convulsions Yes No Incorporation Yes No Incorporation Yes No Convulsions Yes No Incorporation Incor	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Yes Yes Yes Yes Yes Yes Yes	No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No Hives or Rash Yes No Leukemia Yes No Leukemia Yes No Low Blood Pressure Yes No Lung Disease Yes No No Mitral Valve Prolapse Yes No No Osteoporosis Yes No Pain in Jaw Joints Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Paychiatric Care Yes No No Person No No Parathyroid Disease Yes No No Parathyroid Disease Yes No No Paychiatric Care Yes No No No Person No No Person No No Person No No Person No Person No Person No Person No Person No No Person No	No Recent Weight Loss Yes No Renal Dialysis Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Scarlet Fever Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tonsillitis Yes No Tumors or Growths Ulcers Yes No Yes No Yes No Yes No No No Ulcers Yes No Yes Yes Yes No Yes Yes Yes No Yes
Comments:			
To the best of my knowledge, the que dangerous to my (or patient's) health			providing incorrect information can be dical status.
SIGNATURE OF PATIENT, PARENT	, or GUARDIAN		DATE