MEDICAL HISTORY

PATIENT NAME	Birth Date
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.	
Are you under a physician's care now? Yes Meave you ever been hospitalized or had a major operation? Yes Meave you ever had a serious head or neck injury? Yes Meave you taking any medications, pills, or drugs? Yes Meave you take, or have you taken, Phen-Fen or Redux? Yes Meave you on a special diet? Yes Meave you use tobacco? Yes Meave you use tobacco? Yes Meave you use tobacco?	No If yes, please explain: No If yes, please explain: No If yes, please explain: No No No
Do you use controlled substances? Yes No Pregnant/Trying to get pregnant? Yes No Taking oral controlled substances?	raceptives? Yes No Nursing? Yes No
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Other If yes, please explain:	Metal Latex Local Anesthetics
Do you have, or have you had, any of the following? AIDS/HIV Positive	No Hepatitis A
Comments:	
To the best of my knowledge, the questions on this form have been accu dangerous to my (or patient's) health. It is my responsibility to inform the	urately answered. I understand that providing incorrect information can be e dental office of any changes in medical status.
SIGNATURE OF RATIFAL PARENT OF CHARRIAN	DATE