Rudolph _Paino Medical History 20-17- DEFAULT(Copy)

Patient Name: Birth Date: Date Created:

Are you presently under the care of a physician for a specific condition? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Please list all medications & supplements you are currently taking:

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin \ Antibiotics Codeine Acrylic \ Plastic
Latex Local Anesthetics Foods

Other Allergies? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

ADHD/ ADD Yes No	COLDSORE/FEVERBLISTER Yes No	HEMOPHILIA Yes No	PSYCHIATRIC CARE Yes No
AIDS/HIV Yes No	CONVULSIONS Yes No	HEPATITIS Yes No	RADIATION Yes No
ALZHEIMER'S Yes No	CORTISONE MEDICATION Yes No	HERPES Yes No	RHEUMATISM Yes No
ANAPHYLAXIS Yes No	DIABETES Yes No	HIGH BLOOD PRESSURE Yes No	SINUS TROUBLE Yes No
ANGINA Yes No	DRUG ADDICTION Yes No	HYPOGLYCEMIA Yes No	DO YOU SNORE? Yes No
ARTHRITIS/RHUEMATISM Yes No	DRY MOUTH Yes No	IRREGULAR HEARTBEAT Yes No	STOMACH/INTESTINAL DISEASE Yes No
ARTIFICAL HEART VALVE Yes No	EPILEPSY OR SEIZURES Yes No	KIDNEY PROBLEMS Yes No	STROKE Yes No
ARTIFICAL JOINT Yes No	EXCESSIVE BLEEDING Yes No	LEUKEMIA Yes No	THYROID DISEASE Yes No
ASTHMA Yes No	FAINTING SPELLS/DIZZINESS Yes No	LIVER DISEASE Yes No	TOBACCO USER Yes No
BLOOD DISEASE Yes No	FREQUENT COUGH Yes No	LOW BLOOD PRESSURE Yes No	TONSILLITIS Yes No
BREATHING PROBLEMS Yes No	FREQUENT HEADACHES Yes No	LUNG DISEASE Yes No	TUBERCULOSIS Yes No
BRUISE EASILY Yes No	GLAUCOMA Yes No	OSTEOPENIA Yes No	TUMORS/GROWTHS Yes No
CANCER Yes No	HEART ATTACK/FAILURE Yes No	OSTEOPEROSIS Yes No	ULCERS Yes No
CHEMOTHERAPY Yes No	HEART PACEMAKER Yes No	PAIN IN JAW JOINTS Yes No	YELLOW JAUNDICE Yes No
CHEST PAIN Yes No	HEART DISEASE Yes No	PARATHYROID DISEASE Yes No	

Have you ever had any serious illness not listed Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

FOR OFFICE USE ONLY