

Laden & Batra Dentistry <u>Medical History</u>

| Today's Da | ate | | |
|------------|-----|--|--|

| Other If yes, please explain: Do you have, or have you had, any of the following? AlDS/HIV Positive Yes No Diabetes Yes No Hepatitis A Yes No Alzheimer's Disease Yes No Diabetes Yes No Hepatitis Bor C Yes No Leuron Bor C Yes No Hepatitis Bor C Yes No | PATIEN | NT NAME | | | Birth Date | · | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------|-----------------------|-----------------|-------------------------------------------|--------------|----------------------|-------------|
| ave you ever been hosphalized or had a major operation? Yes No If yes, please explain: Have you ever had a revision bead or neck fluiny? Yes No If yes, please explain: Do you take, or have you taken paym medications, pills, or drugs? Yes No Have you ever taken Fosamax, Boniva, Actored or any other medications containing bisphosphonates? Yes No Do you use robacco? Yes No Do you use robacco? Yes No Do you use rothercore? Yes No Do you use rothercore? Yes No Do you use rothercore? Yes No No Nursing? Yes No Nursing? Yes No Are you or a special diet? Yes No Are you or an appeal diet? Yes No Do you use contribried substances? Yes No Nursing? Yes No Nursing? Yes No Nursing? Yes No Are you allergic to any of the following? Asplin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa di Other If yes, please explain: Do you have or have you had, any of the following? Albishirth Penicillin Sulfaction Nursing N | have, or medication | n that you may be | | | | | | |
| Do you take, or have you taken. Phen-Per or Redux? Yes No | ave you ever been h Have you ev | nospitalized or had er had a serious h | a major operation? | Yes No If | yes, please explain: yes, please explain: | | | |
| Do you use tohacco? Yes No Women: Are you PregnantTrying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicililin Codeline Local Anesthetics Acrylic Metal Latex Sulfa di | Do you take, or h Have you ever ta | have you taken, Pi ken Fosamax, Bo | hen-Fen or Redux? | Yes No _ | | | | |
| Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin | Women: Are vou | Do | you use tobacco? | Yes O No | | | | |
| Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa di Other If yes, please explain: Do you have, or have you had, any of the following? AlbSHIP Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes No No Recent Weight Loss Yes Anaphysios Yes No Drug Addiction Yes No Hepatitis A Yes No No Recent Weight Loss Yes Anaphysios Yes No Drug Addiction Yes No Hepatitis Bor C Yes No Herpest Bor C Yes No Herpest Blaters Ves No Expressive Bleeding Yes No High Blood Pressure Yes No Authritat/Out Yes No Excressive Thirist Yes No Hathrat Valve Yes No Frequent Cough Yes No Hathrat Valve Yes No Frequent Cough Yes No Discoasse Yes No Genital Herpes Yes No Cortisorate Yes No Heart Murmur Yes No Parint Jaw Joints Yes No Parint Jaw Joints Yes No Cortisorate Yes No Cortisorate Yes No Heart Murmur Yes No Parint Jaw Joints Yes No Cortisorate Yes No Cortisorate Yes No Heart Murmur Yes No Parint Jaw Joints Yes No Cortisorate Yes No | | get pregnant? | Yes No Taking | oral contracep | tives? Yes No | Nursing? | ○ Yes ○ No | |
| Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes Anaphylaxis Yes No Diabetes Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Diabetes Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Diabetes Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes No Hepatitis Bor C Yes No Recent Weight Loss Yes No Hepatitis Bor C Yes No High Cholesterol Yes No High Cholesterol Yes No High Cholesterol Yes No High Cholesterol Yes No Hepatitis Bor Yes No Hepatitis Bor Yes No High Cholesterol Yes No High Cholesterol Yes No High Cholesterol Yes No Kidney Problems Yes No Sinus Trouble Yes Situs Easily Yes No Gancer Yes No Galacoma Yes No Low Blood Pressure Yes No Somach/Intestinal Disease Yes No Cancer Yes No Heart Attack/Failure Yes No Mitral Valve Prolapse Yes No No Congenital Heart Disorder Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No | Aspirin | Penicillin | | cal Anesthetics | Acrylic | Metal | Latex | Sulfa drugs |
| Alzheimer's Disease Yes No No Lize Wes No Diabetes Yes No Hepatitis A Yes No Hepatitis A Yes No Hepatitis A Yes No No Hepatitis A Yes No Hepatitis B or C Yes No No No Hepatitis B or C Yes No No Hepatitis B or C | | | | | | | | |
| Nutherier's Disease | - | ~ ~ · | | ○ Yes ○ No | Hemophilia | Yes No. | Radiation Treatments | ○ Yes ○ N |
| naphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Incine I and I a | | \simeq | | \simeq | · | × × | | |
| nemia Yes No Emphysema Yes No High Blood Pressure Yes No High Cholesterol Yes No High Cholesterol Yes No High Cholesterol Yes No Kardet Fever Yes Standard Yes No Emphysema Yes No High Cholesterol Yes No Scarlet Fever Yes Standard Yes No Excessive Bleeding Yes No Hives or Rash Yes No Scarlet Fever Yes Standard Yes No Ferequent Discrimes Yes No Introduced Program Yes No Frequent Discrimes Yes No Introduced Program Yes No Frequent Discrimes Yes No Introduced Program Yes No International Program Yes No I | | \simeq | | \simeq | • | Ξ | - | \times |
| rigina Yes No Emphysema Yes No Emphysema Yes No High Blood Pressure Yes No High Blood Pressure Yes No High Cholesterol Yes No No High Cholesterol Yes No No Had Frequent Headachs Yes No Louise Easily Yes No Genital Herpes Yes No Had Feyer Yes No Had Herpes Yes No Had Heart Murmur Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Physichiatric Care Yes No No Heart Pacemaker Yes No Physichiatric Care Yes No No Heart Pacemaker Yes No Parathyroid Disease Yes No No Parathyroid Disease Yes No No Parathyroid Disease Yes No | | \simeq | - | \simeq | • | = = | • | |
| thritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Excessive Bleeding Yes No High Cholesterol Yes No Excessive Bleeding Yes No High Cholesterol Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Might and Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Business Yes No Heart Busine | | \sim | • | \simeq | • • • • • • • • • • • • • • • • • • • • | × × | | |
| tificial Heart Valve Yes No Excessive Bleeding Yes No Hitch Yes No Hitch Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Hypoglycemia Yes No Hypoglycemia Yes No Hypoglycemia Yes No Od Transfusion Yes No Frequent Cough Yes No Heathing Problem Yes No Frequent Blarnhea Yes No Hitch Headaches Yes No User Blied Blisters Yes No No Heart Attack/Failure Yes No Indignated Heart Disorder Yes No Heart Trouble/Disease Yes No Indignated Heart Disorder Yes No Heart Trouble/Disease Yes No Pryschiatric Care Indignated Heart 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. | - | \times | • • | \times | - | ~ ~ | | |
| tificial Joint Yes No Famining Spells/Dizziness Yes No Frequent Cough Yes No God Disease Yes No Heart Attack/Failure Yes No Heart Pacemaker Yes No Heart Proteitor Disease Yes No Parathyroid Disease Yes No Heart Proteitor Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Comments: **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. | | \simeq | | \times | - | × × | | |
| sthma Yes No cod Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Kidney Problems Yes No Kidney Problems Yes No Leukemia Yes No Mitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Osteoprosis Yes No Parathyroid Disease Yes No Psychiatric Care Yes No Psychiatric Care Yes No Psychiatric Care Yes No Comments: **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. | | \times | • | = = | | × × | • | |
| ood Disease Yes No Frequent Cough Yes No Lukernia Yes No Lukernia Yes No Liver Disease Yes No Liver Disease Yes No Storoke Yes No Parity Storoke Yes No | | \times \times \times | | \times | | ~ ~ | | |
| ood Transfusion Yes No Frequent Diarrhea Yes No Eathing Problem Yes No Gathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes No Stroke Yes Yes ancer Yes No Genital Herpes Yes No Hay Fever Yes No Hay Fever Yes No Heart Attack/Failure Yes No Oscoporosis Yes No Oscoporosis Yes No Oscoporosis Yes No Heart Murmur Yes No Heart Disorder Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Psychiatric Care Yes No No No Psychiatric Care Yes No Psychiatric Ca | | \times \times | | × × | • | × × | | X X |
| reathing Problem Yes No Genital Herpes Yes No Genital Herpes Yes No Glaucoma Yes No Hay Fever Yes No Hay Fever Yes No Heart Attack/Failure Yes No obld Sores/Fever Blisters Yes No Heart Trouble/Disease Yes No orwulsions Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Orwulsions New Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Dendental Heart Disorder Yes No Heart Trouble/Disease Yes No Dendental Heart Disorder Yes No Heart Trouble/Disease Yes No Dendental Heart Disorder Yes No Heart Trouble/Disease Yes No Dendental Heart Disorder Yes No Heart Trouble/Disease Yes No Dendental Heart Disorder Yes No Heart Trouble/Disease Yes No Dendental Heart Disorder Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Psychiatric Care Yes No No No Psychiatric Care Yes No | | × × | | × × | | \leq | • | |
| 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. | | \simeq | | | | × × 1 | | |
| Ancer Yes No Hay Fever Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Trouble/Disease Yes No Promised any serious illness not listed above? Yes No Comments: Thyroid Disease Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Pain in Jaw Joints Yes No Pain in Jaw Joints Yes No Parathyroid Disease Yes No Provided Disease Yes No Disease Yes No Provided Disease Yes No Disease Yes No Provided Disease Yes No Provided Disease Yes No Di | - | \times | | \simeq | | | | |
| hemotherapy Yes No hest Pains Yes No heart Murmur Yes No proposed part of the part Murmur Yes No heart Murmur Yes No Pain in Jaw Joints Yes No parathyroid Disease Yes No Posphilatric Care Yes No Psychiatric Care Yes No | uise Easily | \times | | × × | | z z 1 | 0 | |
| hest Pains | | ~ ~ | | ~ ~ | | ~ ~ | , | |
| 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. | | ~ ~ | | X X | | | | |
| 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. | | \simeq | | \simeq | | × × | | |
| Any one of 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. | | × × | | × × | | | | |
| And the dest 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. | - | ~ ~ | | \times | • | × × | | |
| Comments: 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. | onvulsions | ○ Yes ○ No I | Heart Trouble/Disease | ○ Yes ○ No | Psychiatric Care | ∫ Yes () No | Yellow Jaundice | O 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. | Have you ever had | d any serious illnes | ss not listed above? | Yes 🗌 No | _ | | | |
| dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. | Comments: | | | | | | | |
| dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. | | | | | | | | |
| dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. | | | | | | | | |
| dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. | | | | | | | | |
| dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. | | | | | | | | |
| dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. | | | | | | | | |
| | | | | | | | | n can be |
| | | , , , , , , , , , , , , , | , , | | | | | |
| SIGNATURE OF PATIENT, PARENT, or GUARDIAN | CIONATURE OF S | ATIENT DADEL | F or CHARDIAN | | | | DATE | |