PATIENT NAME	DATE		
Primary reason for this dental appointment: Examir	nation Emergency Consultation		
		D'	
Dental History		Please	) (
		Yes	
		Yes	
- Burner 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
		Yes	
		Yes	
		Yes	
Do you want to keep your remaining teeth?		Yes	
	w joint? Do you brux or grind?		
		Yes	
		Yes	
Name of previous dentist (optional):			
	s):		
Medical History			
Are you under a physician's care now? Why?	Who? Phone	Yes	
Have you ever been hospitalized or had a major operation	n? Discuss	Yes	
Have you ever had a serious injury to your head or neck	? Discuss		
Are you taking any medications aspirin vitamins herhals	, pills or drugs? What?	Yes	
Are you on a special diet? Discuss		174.040000000	
		Yes	
		165	
	etal Latex Rubber Milk Other		
		Yes	1
Do you now have or have you ever had any of the follow	ving? Do you take any of these medicines? Please check appropriate boxes.		
*If yes to any of the starred conditions, please call prior	o your appointment premedication or changes in medication may be required.		
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Heart Disease/Surgery* ☐ ☐ Excessive Bleeding ☐	No Yes No	Ε	
Heart Murmur or Defect *  Sickle Cell Disease	Osteoporosis Yellow Jaundice Fever Blisters		
Angina/Chest Pain Hemophilia	☐ Bisphosphonates ☐ ☐ Kidney Problems ☐ ☐ Herpes		
Heart Attack/Failure	Osteonecrosis of Jaw		
Congenital Heart Disorder   Recent Blood Transfusion	Zometa I.V. Parathyroid Disease Epilepsy or Seizures	Ė	
Mitral Valve Prolapse	☐ Fosamax, Actonel, Boniva ☐ ☐ Arthritis/Gout ☐ ☐ Fainting or Dizziness	Ē	j
Rheumatic Fever *	Stomach/Intestinal Disease  Rheumatism Glaucoma		]
Scarlet Fever	Zometa I.V.  Fosamax, Actonel, Boniva  Stomach/Intestinal Disease  Ulcers  Parathyroid Disease Arthritis/Gout Rheumatism Pain in Jaw Joints  Cortisone Medicine  Nervousness	Ξ	
Heart Pace Maker*	Recent Weight Loss Cortisone Medicine Nervousness Frequent Diarrhea Artificial Joint * Psychiatric Care Diabetes Sexually Transmitted Disease Allergies (Medicines)	Ē	1
Pulmonary Shunt*	Prequent Diarmea Artificial Joint Psychiatric Care		1
High Blood Pressure Sinus Trouble	Excessive Thirst AIDS AIDS Allergies (Medicines)	E	
Bacterial Endocarditis*	Hypoglycemia HIV Positive Allergies (Pollen / Dus	st) r	í
Heart Pace Maker*     Frequent Cough   Pulmonary Shunt*   Hay Fever   High Blood Pressure   Sinus Trouble   Low Blood Pressure   Asthma   Bacterial Endocarditis*   Bloody Sputum   Unexplained Fever   Emphysema	Liver Disease Genital Herpes Hives or Rash		
Bruise Easily/Blood Disease			1
Anemia Cancer	Hepatitis B or C   lattoos/Body Piercing   Ever taken ten-phen?		
Coronary Stent*   X-Ray Treatments (Radiation)	Protease Inhibitor		]
Have you ever had any other serious illness not checked	d above? Discuss	Yes	
Do you wish to talk to the dentist privately about any privately a	roblem?	Yes	
	any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointme	ent with	OU
X			
PATIENT SIGNATURE (PARENT OR GUARDIAN)	Date		_
Reviewed By Doctor	Date BP Pulse	Mark State	
1			
History Review and Significant Findings	이 보다 이 가다는 바이를 하는 것이 없는 바다 가는 사람이 되었다. 그리고 하는 사람이 되었다면 하는 사람이 되었다면 하는데		No.
History Review and Significant Findings			
SCHOOL SCHOOL STATE OF THE SCHOOL SCH			
Medical Updates			
Medical Updates	and confirm that it adequately states next and present acciditions		
Medical Updates I have read my MEDICAL HISTORY dated	and confirm that it adequately states past and present conditions.		
Medical Updates	PATIENT'S SIGNATURE BP PULSE REVIEWED BY		
Medical Updates I have read my MEDICAL HISTORY dated	PATIENT'S SIGNATURE BP PULSE REVIEWED BY None  Dr.		
Medical Updates I have read my MEDICAL HISTORY dated	PATIENT'S SIGNATURE BP PULSE REVIEWED BY		
Medical Updates I have read my MEDICAL HISTORY dated	None Dr. PATIENT'S SIGNATURE BP PULSE REVIEWED BY Dr.		
Medical Updates I have read my MEDICAL HISTORY dated	None		
Medical Updates I have read my MEDICAL HISTORY dated	None		
Medical Updates I have read my MEDICAL HISTORY dated	None		