MEDICAL HISTORY

PATIENT NAME Elizabeth HICKS Birth Date 10/09/1969

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	If yes, please explain:	General Practiioner - basic checkups
Have you ever been hospitalized or had a major operation?	Yes	If yes, please explain:	appendectomy, c-section, hysterectomy
Have you ever had a serious head or neck injury?	No	If yes, please explain:	
Are you taking any medications, pills, or drugs?	Yes	If yes, please explain:	Lisinopril (High BP); Bupropion (hot flashes)
Do you take, or have you taken, Phen-Fen or Redux?	No		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	No		
Are you on a special diet?	Yes		
Do you use tobacco?	No		
Do you use controlled substances?	No		

Women: Are you Pregnant/Trying to get pregnant? No Taking oral contraceptives? No Nursing? No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: Allergic to ALL sulfa-based meds....online form would NOT allow me to 'check just one'

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

AIDS/HIV Positive	No	Cortisone Medicine	Yes	Hemophilia	No	Radiation Treatments	No
Alzheimer's Disease	No	Diabetes	No	Hepatitis A	No	Recent Weight Loss	No
Anaphylaxis	No	Drug Addiction	No	Hepatitis B or C	No	Renal Dialysis	No
Anemia	No	Easily Winded	No	Herpes	No	Rheumatic Fever	No
Angina	No	Emphysema	No	High Blood Pressure	Yes	Rheumatism	No
Arthritis/Gout	Yes	Epilepsy or Seizures	No	High Cholesterol	Yes	Scarlet Fever	No
Artificial Heart Valve	No	Excessive Bleeding	No	Hives or Rash	Yes	Shingles	No
Artificial Joint	No	Excessive Thirst	No	Hypoglycemia	Yes	Sickle Cell Disease	No
Asthma	No	Fainting Spells/Dizziness	Yes	Irregular Heartbeat	No	Sinus Trouble	Yes
Blood Disease	No	Frequent Cough	No	Kidney Problems	No	Spina Bifida	No
Blood Transfusion	No	Frequent Diarrhea	No	Leukemia	No	Stomach/Intestinal Disease	No
Breathing Problem	No	Frequent Headaches	No	Liver Disease	No	Stroke	No
Bruise Easily	Yes	Genital Herpes	No	Low Blood Pressure	No	Swelling of Limbs	Yes
Cancer	No	Glaucoma	No	Lung Disease	No	Thyroid Disease	No
Chemotherapy	No	Hay Fever	Yes	Mitral Valve Prolapse	No	Tonsillitis	No
Chest Pains	No	Heart Attack/Failure	No	Osteoporosis	Yes	Tuberculosis	No
Cold Sores/Fever Blisters	No	Heart Murmur	No	Pain in Jaw Joints	No	Tumors or Growths	No
Congenital Heart Disorder	No	Heart Pacemaker	No	Parathyroid Disease	No	Ulcers	No
Convulsions	No	Heart Trouble/Disease	No	Psychiatric Care	No	Venereal Disease	No
						Yellow Jaundice	No

Have you ever had any serious illness not listed above? No

Comments: Previous risk of CLOTS; migraines

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 Elizabeth Hicks Digitally signed by Elizabeth Hicks Date: 2016.08.16 10:36:50 -05'00' DATE 8/16/16