Dental & Cosmetic Sloutions, L.L.C.

Medical History

Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Rheumatic Fever Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Rheumatism Yes No Anamia Yes No Easily Winded Yes No Herpes Yes No Scarlet Fever Yes No Angina Yes No Emphysema Yes No Herpes Yes No Schingles Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Singles Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Artificial Joint Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sinus Trouble Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Simus Trouble Yes No Asthma Yes No Fainting Spells/Dizzines Yes No Kidney Problems Yes No Stroke Yes No Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Stroke Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Stroke Yes No Breathing Problem Yes No Frequent Headaches Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Tonsillitis Yes No Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Chemotherapy Yes No Hay Fever Yes No Pain In Jaw Joints Yes No Tumors or Growths Yes No Congenital Heart Disorder Yes No Heart Attact/Failure Yes No Pain In Jaw Joints Yes No Yellow Jaundice Yes No Congenital Heart Disorder Yes No Heart Mirmur Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Comments:	PATIENT NAME				Birth	n Date							
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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.	AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blister Congenital Heart Disorde Convulsions	Yes	No N	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizzine: Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease	Yes	S NG	Hepatitis A Hepatitis B Herpes High Blood I Hives or Ra Hypoglycem Irregular He Kidney Prob Leukemia Liver Diseas Low Blood F Lung Diseas Mitral Valve Pain in Jaw Parathyroid Psychiatric C Radiation Tr Recent Weig	Pressure sh nia artbeat olems se Pressure se Prolapse Joints Disease Care reatments ght Loss	Yes	No N	Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	Yes	6 No
Comments:								· ·					_
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 DATE	To the best of my knowl dangerous to my (or part	ledge, the tient's) hea	questic	ons on this form have l	been acc	curatel	y answered. Tu	understa	nd that p	orovidin	g incorrect information ca		_