Fairbourn Family Dentistry MEDICAL HISTORY

Loose teeth or broken fillings Yes No Mouth breathing Yes No Mouth breathing Yes No Mouth pain when brushing Yes No Grinding teeth Yes No Sensitivity when biting Yes No Sens or growths in your mouth Yes No Sens day and or tiredness Yes No Sens day and or tiredness Yes No How often do you brush? Loose teeth or broken fillings Yes No Mouth peak providing yes No Mouth peak providing yes No Amouth yes No Sensitivity to cold Yes No Sensitivity to cold Yes No Sensitivity to cold Yes No Sensitivity to that Yes No Sensitivity to sweets Yes No Sensitivity when biting Yes No Sores or growths in your mouth Yes No How often do you brush? How often do you floss? Do you dethor or broken fillings Yes No Mouth preathing Yes No Mouth preathing Yes No How often do you floss? 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	PATIENT NAME							Birth Da	ite							
Are you under a physician's care now? Have you ever been hospitalized or heat a major operation? Yes Are you taking any medications, pills, or drugs? Are you taking any medications, pills, or drugs? Are you take, or have you taken, Phen-Fan or Redux? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fan or Redux? Yes No Do you use controlled substances? Do you use controlled substances? Do you use controlled substances? Do you need to pre-medicate? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Do you have, or have you had, any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Do you have, or have you had, any of the following? AlDSHIV Positive Yes No Corisone Medicine Yes No Hemophilia Yes No Renal Dialysis Yes No Anaphylaus Yes No Diabetes Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Diabetes Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaus Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Medicine Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Renal Medicine Yes No Hepatitis B or C Yes No Hepatitis B	have, or medication that		-			-		-			-		-		-	
Have you ever been hosphalized or had a major operation? Yes Have you ever had a serous head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Prien-Pen or Redu? Are you no a special diet? Do you use controlled substances? Yes No Do you use controlled substances? Do you need to pre-medicate? Per you no a special diet? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Women: Are you Pregnant/Trying to get pregnant? Aspirin Pencillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain; Do you have, or have you had, any of the following? Altheimer's Disease Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Hepatitis A Yes No Renauticifever Yes No Angina Yes No Angina Yes No Easily Winded Yes No Easily Winded Yes No Exployeer of selecting Yes No Hepatitis A Yes No Hepatitis B or C Yes No Renauticifever Yes No Sanite Fever Yes No Angina Yes No Sanite Fever Yes No Angina Yes No Exployeer Seizures Yes No Hepatitis A Yes No Sanite Fever Yes No Angina Yes No Sanite Fever Yes No Angina Yes No Excessive Bleeding Yes No Frequent Cough Yes No Excessive Filted herbiting Yes No Hepatitis Care Yes No Hepatitis Care Yes No Social Fever Yes No No Hepatitis Care Yes No Social Fever Yes No No Hepatitis Care Yes No Social Fever Yes No No Hepatitis Care Yes No Social Fever Yes No No Hepatitis Care Yes No Social Fever Yes No No Hepatitis Care Yes	- ·	ou un	der a ni	hveician'e care r	10W2	Yes	No	If yes nie:	asa avr	olain:						
Have you ever had a senous head of neck injury? Yes Are you taken, or have you taken, Phen-Fen or Redux? Yes Do you take, or have you taken, Phen-Fen or Redux? Yes Do you use controlled substances? Yes Do you use controlled substances? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Wmen: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain: Wmen: Are you aftergic to any of the following? Aspirin Pencillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: Other If yes, please explain																
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