Solar Dental™

MEDICAL HISTORY

ALLERGIES

Do you have any allergies?

MEDICAL CONDITIONS

Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)

Lung Disease	NO	NS	YES	Stomach/Intestinal Problems	NO	NS	YES
Bronchitis				Head/Neck Injuries			
Tuberculosis				High Blood Pressure/Hypertension			
Liver Disease				Low Blood Pressure			
Hepatitis A/B/C				Heart Failure			
Yellow Jaundice				Congential Heart Lesion			
Thyroid Disease				Artificial Heart Valve			
Cancer				Heart Pacemaker			
Rheumatic Fever				Heart Surgery			
Artificial Joints/Hips				Chest Pain/Angina			
Diabetes				Heart Murmur			
Arthritis/Rheumatism				Mitral Valve Prolapse			
Epilepsy or Seizures				Shortness of Breath			
Glandular Disorders				Stroke			
Mental/Nervous Disorders				Fainting or Dizziness			
AIDS (HIV Positive)				Anemia			
Venereal Disease				Cardiac Arrest/Heart Attack			
Herpes				Scarlet Fever			
Blood Disorders				Kidney Trouble			
Sickle Cell Anemia				Asthma			
Hemophilia				Sinus Trouble			
Chemotherapy/Radiotherapy to head or neck				Emphysema			

Is there anything you have not mentioned that you think we should know regarding your medical history?

WOMEN ONLY

Are you pregnant?	YES		NO		Are you taking birth control pills?	YES		NO	
Are you nursing?	YES		NO		Are you taking fertility drugs?	YES		NO	

Follow-up information to above quesions?