## GLENN S. LUDWIG, D.M.D., P.C.

Medical History:

		Date	
Name	267	_ Date of Birth	Age
Occupation		_ Spouse's Name	
Home Address	Charles and	liasir o memeringa alige termi o e	Manager T
	Zip Code	_ Home Telephone No	
Business Address	Seekin Chenkler	er skej ban odasch a va tiko sveja sec	and the second second
		_ Business Telephone No	
Which telephone would be bes	st for messages?	formeren acces beloats the color	
		o presidency procedurations and as a Constitution with management floring on the	
What made you select this office	ce?	control but her tack happen has been	manual ar
Address	Such descriptions of the first state	Entrals Even DOV 16th Stoy Unit Year Te	
		_ Telephone No	
Your Physician's Name		i - Nichara VA pesant masé san Calum an	augraphyter ST
Address	Necral par	elius vojamentema i baseja suo	e gray more and
	Zip Code	_ Telephone No	
Date of last medical examination	on	no anal service entire process bearing.	Post Mesself Serv
Name of parent (if minor)			CONTRACTOR NO.
Address		Particular National States	ist was take the
	Zip Code	_ Telephone No	
What dental and major medica	l insurance do you hav	e?	
Social Security or Insurance I.I	D. number	NO SE ME E	Market M
What is your present problem	and what would you like	e to have handled today?	
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	No.	endano nere i neve su evento para	street is

PLEA	ASE WRITE BRIEF ANSWER IF APPROPRIATE	YES	NO	DK*
1.	Do you consider yourself to be in good health?			
2.	Are you under the care of a physician?			
3.	Have you had any illnesses, operations or been hospitalized?		Marian 3 - Essi	
4.	Do you have unhealed injuries or inflamed areas, growths or			
	sore spots in or around your mouth?			
5.	Do you have a prosthetic replacement that requires			
	premedication (i.e. knee, hip, wrist, leg)?			
6.	Have you ever had rheumatic heart disease, rheumatic fever or tuberculosis?		motive	
7.	Do you have a heart valve replacement or vascular graft?			
8.	Have you ever been told you have mitral valve prolapse or a heart murmur?			
9.	Have you ever been told by a doctor that you have high or low blood pressure?			
10.	Have you ever been told by a doctor that you have heart trouble?			
11.	Do you have a cardiac pacemaker?			
12.	Do you have asthma?			
13.	Have you ever had chronic sinus infections?			
14.	Have you ever received treatment for any type of endocrine disorder (i.e. thyroid)?			
15.	Do you have or has anyone in your family had diabetes?			
16.	Did a doctor ever tell you that you had kidney or bladder trouble?			
17.	Do you have swollen ankles, arthritis or joint disease?		TOWN IS	
18.	Have you ever tested positive for an autoimmune disease?	rosid e		
19.	Has a doctor ever told you that you have stomach ulcers or stomach trouble?			
20.	Have you ever been treated for jaundice, hepatitis or liver disease?			
21.	Have you ever had abnormal bleeding following a cut or dental extraction?			
22.	Have you ever been treated for anemia?			
23.	Do you bruise easily?	<b>特别</b>	CAPPET.	
	Have you ever received chemotherapy or radiation therapy?			
	Has a doctor ever told you that you have osteoporosis?			
	Are you on any special type of diet?			
27.	Have you ever had severe pains of the face or head?			
28.	Do you consider yourself nervous?			
29.	Do you smoke cigarettes, cigars, or a pipe?		1000	
30.	Are you taking any medications?			
	If so, please list:			
31.	Do you take a daily aspirin?			
32.	Have you ever taken cortisone?			
33.	Are you allergic to or had a reaction to any medication? (aspirin, Ibuprofen,			
	Codeine, Penicillin, Tetracycline, Sulfa, Other:)			
34.	Do you have a latex allergy?			
35.	(Women) Do you take birth control pills?	TR WE		
36.	(Women) Are you pregnant?		2	
37.	(Women) Have you ever had hormone replacement therapy?			
38.	(Women) Do you have any unusual hormonal or gynecological difficulties?			
39.	Are you taking or have you ever taken bisphosonates?			
			*DK - Do	n't Know