MEDICAL HISTORY

Patient's Name:	**Date of Birth:**

ALLERGIES

Aspirin:	YES	NO
Codeine:	YES	NO
Latex:	YES	NO
Local Anesthetic:	YES	NO
Penecillin:	YES	NO
Sulfa:	YES	NO

List any other allergies:

Medical Conditions

Abnormal (High/Low) Blood Pressure:	YES	NO
AIDS/HIV:	YES	NO
Anemia/Bleeding Problems:	YES	NO
Artificial Heart Valves:	YES	NO
Blood Disease:	YES	NO
Congenital Heart Lesions:	YES	NO
Heart Problems:	YES	NO
Pacemaker:	YES	NO
Arthritis/Rheumatism/Gout:	YES	NO
Artificial Joints/Bones:	YES	NO
Asthma:	YES	NO
Cancer:	YES	NO
Chemotherapy:	YES	NO
Diabetes:	YES	NO
Emphysema:	YES	NO
Glaucoma:	YES	NO
Radiation Treatment (X-Ray/Cobalt):	YES	NO
Shortness of Breath (Breathing Problems):	YES	NO
Sinus Trouble:	YES	NO
Stroke:	YES	NO
Thyroid Problems:	YES	NO
Tuberculosis:	YES	NO
Tumor/growth on head/neck:	YES	NO
Ulcer:	YES	NO
Epilepsy:	YES	NO
Fainting/Dizziness:	YES	NO
Headaches (Frequent):	YES	NO
Hepatitis:	YES	NO

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Herpes:	YES	NO
Kidney Disease:	YES	NO
Liver Disease:	YES	NO
Nervous Problems:	YES	NO
Psychiatric Care:	YES	NO

List any other medical issuaes you have:

List any serious illnesses/surgeries/ hospitalizations:

List any medications you are currently taking:

Pregnant:	YES	NO
Nursing:	YES	NO
Do you drink alcohol:	YES	NO
Do you smoke:	YES	NO

Signature:	**Date:**