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Medical History

Patient Name: _____ Date:_____

PLEASE CHECK

(Y) (N) 1. Has there been any change in your general health within the last year?
(Y) (N) 2. Are you presently, or have you been under the care of a physician during the past year?
(Y) (N) 3. Have you had any serious illness, operation, or been hospitalized within the last 5 years?
(Y) (N) 4. Are you taking any medicine(s) including non-prescription drugs? *If yes, list below.*

_____

_____

(Y) (N) 5. Do you have or have you had a problem with alcohol or drug abuse?
(Y) (N) 6. Do you use or have you used tobacco products? (smoke/smokeless)

WOMEN

(Y) (N) 7. Are you pregnant?
(Y) (N) 8. Do you take birth control pills?

9. Are you allergic or have you had a reaction (swelling, rash, itching) to: *Check all that apply.*

- ◯ Penicillin or other antibiotics
- ◯ Local anesthetics (numbing agents)
- ◯ Other drugs or medications
- ◯ Latex/rubber products
- ◯ Metals/Jewelry
- ◯ Other _____

10. Have you now, or in the past, had any of the following: *Check all that apply.*

- ◯ Heart trouble/surgery
- ◯ Diabetes/family history
- ◯ Heart murmur
- ◯ Cancer or tumor
- ◯ Lumps or swollen glands
- ◯ AIDS/HIV infection
- ◯ Shortness of breath
- ◯ Sinus problems
- ◯ Seizures/fainting
- ◯ Persistent cough
- ◯ Stomach/Intestinal problems
- ◯ Abnormal prolonged bleeding
- ◯ Jaundice or other liver problems
- ◯ Rheumatic fever
- ◯ Kidney/bladder problems
- ◯ Mitral valve prolapse
- ◯ Sudden weight loss or gain
- ◯ Stroke
- ◯ Hay fever/asthma
- ◯ Scalp or skin disease
- ◯ Tuberculosis
- ◯ Artificial joints
- ◯ Sickle cell disease
- ◯ Indwelling catheter/shunt
- ◯ Chest pain
- ◯ Thyroid problems
- ◯ Irregular heart beat
- ◯ Pacemaker
- ◯ High blood pressure
- ◯ Venereal disease
- ◯ Herpes
- ◯ Emphysema
- ◯ Arthritis
- ◯ Anemia/blood diseases
- ◯ Emotional problems
- ◯ Hepatitis

11. If you have any diseases, conditions, or problems not listed above, please explain.

_____

_____

I certify that to the best of my knowledge the above information is complete and accurate. If there are changes in my health, or medicines, I will inform my doctor at the next appointment.

Signature of Patient/Guardian _____ Date_____