MEDICAL HISTORY

ALLERGY?

- Aspirin? (YES/NO)
- Codeine? (YES/NO)
- Latex? (YES/NO)
- Local Anesthetic? (YES/NO)
- Penicillin? (YES/NO)
- Sulfa? (YES/NO)
- List any other allergies:

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CIRCLE YES/NO.

- Abnormal (High/Low) Blood Pressure? (YES/NO)
- 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? (YES/NO)
- Asthma? (YES/NO)
- Cancer? (YES/NO)
- Chemotherapy? (YES/NO)
- Diabetes? (YES/NO)
- Emphysema? (YES/NO)
- Glaucoma? (YES/NO)
- Radiation Treatment (Xray/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 or neck? (YES/NO)
- Ulcer? (YES/NO)
- Epilepsy? (YES/NO)
- Fainting? (YES/NO)
- Dizziness? (YES/NO)
- Headaches (Frequent)? (YES/NO)
- Hepatitis? (YES/NO)
- Herpes? (YES/NO)
- Kidney Disease? (YES/NO)
- Liver Disease? (YES/NO)
- Nervous Problems? (YES/NO)
- Psychiatric Care? (YES/NO)
- List any other medical issues you have:

- Do you Smoke? (YES/NO)
- Do you drink Alcohol? (YES/NO)
- High Sugar intake? (YES/NO)

List any serious Illnesses / surgeries / hospitalizations:

Are you taking any medications (required)? (YES/NO)
List medications you are taking:

Is the patient under the care of a physician? (YES/NO)

Physician Name:

Example value

Physician Phone Number:

Example value

Has the patient ever been hospitalized? (YES/NO)

Please state the reason for hospitalization:

Is the patient physically, mentally or emotionally impaired? (YES/NO)

Describe the patient's current physical health:

- GOOD ×
- FAIR ×
- POOR ×

Signature

2024