MEDICAL HISTORY

Patient Name:_____ Today's Date:_____ Date of Birth:_____

1. Other than routine visits, have you been under the care of a medical doctor during the past two years?
   Yes:_____ No:_____
   If yes, for what?_____
   Physician's Name:_____ Phone:_____
   Address:_____ City:_____ State:_____ Zip:_____
2. Have you taken any medications or drugs during the past two years? Yes:_____ No:_____
3. Are you taking any medications now? Yes:_____ No:_____
   If yes, please list name and dosage:_____
4. Have you had a bad reaction to any of the following:
   Aspirin:_____ Codeine:_____ Nitrous Oxide:_____ Tetracycline:_____ Valium:_____
   Clindamycin:_____ Novocain:_____ Anesthetic:_____ Ibuprofen:_____ Erythromycin:_____
   Percodan:_____ Penicillin:_____ Sulfa:_____ Sleeping Pills:_____
   Any others not listed:_____
5. Indicate which of the following you have had, or have presently. Check Yes or No to each item.

	Yes	No		Yes	No		Yes	No
Heart (surgery, disease, attack)	☐	☐	Ulcers	☐	☐	Hepatitis A or B	☐	☐
Chest Pain	☐	☐	Latex Sensitivity	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disease	☐	☐	Diabetes	☐	☐	AIDS	☐	☐
Heart Murmur	☐	☐	Thyroid Problems	☐	☐	HIV Positive	☐	☐
High Blood Pressure	☐	☐	Glaucoma	☐	☐	Cold Sores/Fever Blisters	☐	☐
Mitral Valve Prolapse	☐	☐	Contact Lenses	☐	☐	Blood Transfusion	☐	☐
Artificial Heart Valve	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐
Pacemaker	☐	☐	Chronic Cough	☐	☐	Sickle Cell Disease	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Bruise Easily	☐	☐
Arthritis/Rheumatism	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐
Cortisone Medication	☐	☐	Hay Fever	☐	☐	Jaundice	☐	☐
Swollen Ankles	☐	☐	Allergies or Hives	☐	☐	Neurological Disorder	☐	☐
Stroke	☐	☐	Sinus Trouble	☐	☐	Epilepsy or Seizures	☐	☐
Diet (special/restricted)	☐	☐	Radiation Therapy	☐	☐	Fainting or Dizzy Spells	☐	☐
Artificial Joints	☐	☐	Chemotherapy	☐	☐	Anxiety	☐	☐
Kidney Trouble	☐	☐	Tumors	☐	☐	Psychiatric/Psychological Care	☐	☐

6. Do you take blood thinner or aspirin daily? Yes:_____ No:_____
7. Have you lost or gained more than 10 pounds in the past year? Yes:_____ No:_____
8. Do you have or have you had any disease, condition or problem not listed? Yes:_____ No:_____
   If yes, please list:_____
9. Women: Are you pregnant? Yes:_____ No:_____ If yes, how far along are you?_____
10. Nursing? Yes:_____ No:_____ Taking birth control pills? Yes:_____ No:_____
11. List any allergies to medicaitons:_____
12. List any allergies to food or other:_____
13. Smoker? Yes:_____ No:_____
14. Smokeless Tobacco? Yes:_____ No:_____

Signature:_____ Date:_____