Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Allergy : YES / NO

Aspirin : YES / NO

Allergy : YES / NO

Codeine : YES / NO

Allergy : YES / NO

Latex : YES / NO

Allergy : YES / NO

Local Anesthetic : YES / NO

Allergy : YES / NO

Penicillin : YES / NO

Allergy : YES / NO

Sulfa : YES / NO

List any other allergies: : YES / NO

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

Herpes : YES / NO

Kidney Disease : YES / NO

Liver Disease : YES / NO

Nervous Problems : YES / NO

Psychiatric Care

List any other medical issues you have\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any serious Illnesses / surgeries / hospitalizations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you are taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant **: YES / NO**

Nursing : YES / NO

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_