Medical History

Circle if you have or had any of the following:

Abnormal Bleeding
Artificial Heart Valves
Blood Disease
Circulatory Problems
Cough Up Blood
Fainting
Heart Murmur
Hemophilia
HIV Positive
Mitral Valve Prolapse
Radiation Treatment
Scarlet Fever
Stroke
Tonsillitis

Anemia
Artificial Joints
Cancer
Cortisone Treatments
Diabetes
Glaucoma
Heart Problems
Hepatitis
Kidney Disease
Nervous Problems
Respiratory Disease
Shortness of Breath
Swelling of Feet or Ankles
Tuberculosis

Arthritis, Rheumatism
Asthma
Chemotherapy
Cough, Persistent
Epilepsy
Headaches
High/Low Blood Pressure
Liver Disease
Pacemaker
Rheumatic Fever
Skin Rash
Thyroid Problems
Ulcer
Venereal Disease

Describe Any Conditions: ______________________________

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Allergies: *(circle)*

Aspirin
Local Anesthetic

Codeine
Penicillin

Erythromycin
Sulfa

List Any Allergies: ______________________________

Medications: *List all current medications:* ______________________________

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Hospitalizations: *Have you been hospitalized or had any major operation in the past 5 years?*

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Women:

- Pregnant/trying to get pregnant
- Nursing
- Taking oral contraceptives

To the best of my knowledge, all of the above answers are true and correct.

______________________________ ______________________________

Signature of Patient, Parent or Guardian Date

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