Medical History

Do you have a known allergy to the following? Please answer **YES** or **NO**:

Aspirin	**Yes**	**No**
Codeine	**Yes**	**No**
Latex	**Yes**	**No**
Local Anesthetic	**Yes**	**No**
Penicillin	**Yes**	**No**
Sulfa	**Yes**	**No**

List any other allergies:

_____

_____

Please answer **YES** or **NO** to the following:

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 (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 / 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	**Yes**	**No**

List any other medical issues you have:

_____

_____

List any serious Illnesses / surgeries / hospitalizations:

_____

_____

Are you taking any medications? **Yes** **No** (required)

List medications you are taking:

_____
_____

Do you Smoke?	**Yes**	**No**
Do you drink Alcohol?	**Yes**	**No**
High Sugar intake?	**Yes**	**No**
Pregnant	**Yes**	**No**
Nursing	**Yes**	**No**

Is the patient under the care of a physician?

Physician Name:

Physician Phone Number:

Has the patient ever been hospitalized?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**

Patient Signature: _____ Date Signed:_____