Medical History

Name___________________________________ Date________________ General State of Health: **Good (__) Fair (__) Poor (__)**

Name/Address/Number of Physician____

Have you been under a physician's care during the past two years? ____

Have you been treated in the hospital during the past three years? ____

Have you had any **Major Surgery?** _______What/ When____

Do you or Have you been told to Premedicate before appointments?___________ **Do you take Blood Thinners?**___________

If Female: Are you pregnant? ____________________ Nursing? ____________________ On Birth Control?____________________

Do you or have you had any of the following?

Yes / No

( ) ( ) Aids / HIV+
( ) ( ) Arthritis
( ) ( ) Artificial Heart Valves
( ) ( ) Artificial Joints
( ) ( ) Asthma
( ) ( ) Bruise / Bleed Easy
( ) ( ) Cancer
( ) ( ) Chemotherapy
( ) ( ) Chest Pain / Angina
( ) ( ) Congenital Heart Lesions
( ) ( ) Diabetes
( ) ( ) Dry Mouth
( ) ( ) Emphysema / Bronchitis
( ) ( ) Epilepsy / Seizures
( ) ( ) Fainting / Dizziness
( ) ( ) Fibromyalgia
( ) ( ) Heart Problem / Murmur
( ) ( ) Heart Surgery
( ) ( ) Hepatitis A, B, C, D, E

Yes / No

( ) ( ) High Blood Pressure
( ) ( ) Irregular Heart Beat
( ) ( ) Kidney Problems
( ) ( ) Liver Disease
( ) ( ) Mitral Valve Prolapse
( ) ( ) Nervousness / Anxious
( ) ( ) Organ Transplant
( ) ( ) Pacemaker
( ) ( ) Persistent Cough
( ) ( ) Pneumonia
( ) ( ) Radiation Fever
( ) ( ) Rheumatic Fever
( ) ( ) Sickle Cell Anemia
( ) ( ) Sinus Problems
( ) ( ) Stroke
( ) ( ) Thyroid Disease
( ) ( ) Tobacco Use
( ) ( ) Tuberculosis / PPD+
( ) ( ) Venereal Disease

Do you have any Condition, Disease, or Problem not listed above?

____

____

____

Do you have any medication allergies? If yes, please specify

Yes / No

( ) ( ) Antibiotics (Erythromycin/Tetracycline/Penicillin/Flagyl)
( ) ( ) Aspirin / Acetaminophen / Ibuprofen
( ) ( ) Codeine

Yes / No

( ) ( ) Dental Anesthetics
( ) ( ) Latex
( ) ( ) Sulfa

Any not listed ____

Please list all medications you are taking, including over the counter drugs and herbs______________________________

____

____

____