

# Medical History

Physician (name and address)

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Please ✓

- Yes  No Are you presently under a physician's care? If yes, why? \_\_\_\_\_
- Yes  No Have you ever been hospitalized or had a serious illness or accident? Please explain: \_\_\_\_\_
- Yes  No Are you taking any drugs or medication? If yes, please list: \_\_\_\_\_
- Yes  No Are you allergic to any medications?
- Penicillin  Codeine  Local anesthetic  Other: \_\_\_\_\_
- Yes  No Do You:  Smoke?  Use chewing tobacco? How much? \_\_\_\_\_

*Do any of the following apply to you now or in the past?*

Please ✓

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart (disease, attack, surgery) | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain                       | <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV positive            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart defect          | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial joint/prosthesis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung disease (TB, emphysema) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/hay fever             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral valve prolapse            | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus trouble                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial heart valve           | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart pacemaker                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory problem              | <input type="checkbox"/> Yes <input type="checkbox"/> No Cold sores/fever blisters    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal blood pressure          | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies/hives              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex sensitivity            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal bleeding                | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood disorder                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/rheumatism         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise easily                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Back problem                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Yes  No Do you have any disease, condition or problem not listed? Please explain: \_\_\_\_\_

Yes  No Has it ever been recommended that you be premedicated for any of the above conditions? If yes, reason: \_\_\_\_\_