Medical History

Physician (name and address)

_____

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 expl

☐ 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 ✓

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

☐ 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 c

If yes, reason:_____