

CONFIDENTIAL MEDICAL HISTORY

NAME: _____ HEIGHT: _____ WEIGHT: _____ DATE: _____

REASON FOR TODAY'S VISIT? _____

IF YOU WERE IN AN ACCIDENT, PLEASE DESCRIBE: _____ DATE: _____

PLEASE CHECK ANY CONDITION THAT APPLIES OR HAS APPLIED TO YOU AND EXPLAIN BELOW:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> HEART CONDITION | <input type="checkbox"/> ASTHMA OR HAY FEVER | <input type="checkbox"/> STROKE | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> CONVULSIONS OR SEIZURES | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> CONGESTIVE HEART FAILURE | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> PERSISTENT COUGH | <input type="checkbox"/> NERVE DISORDERS | <input type="checkbox"/> HEPATITIS OR JAUNDICE |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> COUGH BLOOD | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> ULCER OR COLITIS |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> INFLAMMATORY RHEUMATISM |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> ANGINA (CHEST PAIN) | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CANCER | <input type="checkbox"/> JOINT REPLACEMENT |
| <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> BLOOD DISORDER | <input type="checkbox"/> RADIATION TREATMENT | <input type="checkbox"/> OTHER |

YES NO PLEASE CHECK YES OR NO:

Are you taking any medicine, drug or pill for any purpose? If so, what? _____

Are you allergic or sensitive to any drugs such as penicillin, codeine, aspirin, etc.? If so, what?

Are you under the care of a physician?
The name and address of my physician is:

My last physical exam was: _____

Have there been any changes in your general health within the past year?

Have you ever had any operations or serious illness?

Have you been hospitalized or had a serious illness within the past five (5) years?

Have you ever had problems with local anesthetics, sedatives or general anesthetic?

Do you have a latex allergy?

YES NO PLEASE CHECK YES OR NO:

Do you smoke or chew tobacco?

Have you ever taken anticoagulants (blood thinners)?

Have you ever taken any medicines for high blood pressure or heart disease?

Have you ever taken cortisone or any other steroid?

Have you ever taken antidepressants, sedatives or tranquilizers?

Have you ever had prolonged bleeding, following a minor cut, surgery, extraction or ever required a blood transfusion?

Have you ever had hives, wheezing or breathing difficulties from medicines or foods?

Do you have any difficulty breathing through your nose?

Do you wear contact lenses or any removable dental appliance?

Do you have any disease, condition or problem not listed above that you think I should know about? If so, what? _____

Do you have sleep apnea?

WOMEN:

Are you pregnant?

Are you nursing?