MEDICAL HISTORY

Please circle yes or no

Yes No Are you taking any prescription, over the counter medicine, supplements, or drugs of any kind? If so, please list:

____

Yes No Are you allergic to any medicine? If so, please list:
____

Yes No Have you ever had an adverse reaction to local or general anesthesia?

Yes No Have you ever taken any steroid or cortisone medicine?

Yes No Have you seen a doctor within the last year for a medical problem?

Yes No Have you ever been hospitalized for illness, injury, or surgery? If so, please list:
____

Yes No Have you had a blood transfusion or blood product in the last 5 years?

Circle any of the following you have ever had:

a. heart trouble **b.** rheumatic or scarlet fever **c.** heart murmur **d.** chest pain **e.** high blood pressure **f.** shortness of breath **g.** lung problem **h.** chronic cough **i.** asthma **j.** pneumonia **k.** hay fever **l.** tuberculosis **m.** emphysema **n.** spitting up blood **m.** anemia

Yes No Have you ever had a disease of the stomach or gastro-intestinal tract, such as ulcer, colitis, or diverticulitis?

Yes No Have you ever had any liver problem, such as hepatitis or jaundice?

Yes No Have you ever had a disease of the kidney or urinary tract?

Yes No Have you ever been treated for diabetes? Are you taking insulin?

Yes No Have you ever had a thyroid issue?

Yes No Have you ever had a tumor or been treated for cancer? Have you ever had radiation treatment?

Yes No Have you ever been treated for epilepsy?

Yes No Have you ever had psychiatric treatment?

Yes No Have you ever had excessive bleeding after surgery, including dental extraction?

Yes No Do you wear contacts?

Yes No Do you smoke or use tobacco products? Please list:____________________________________

Yes No Do you have an immune deficiency disorder, or are you taking an immuno-suppressant drug?

Yes No Do you have an implanted body part, such as hip, knee, heart valve, teeth?

Yes No Do you wish to talk to the doctor privately about anything? ______________________________

Women: Are you planning pregnancy? Yes No

Are you pregnant? Yes No Have you given birth? Date(s):______________

Signature____ **Date:**______________rev

9/2/2015

MEDICAL HISTORY

Breastfeeding? Yes No

Signature______________________________ **Date:**______________ rev