

Medical History

Allergy Y/N

Aspirin Y/N

Allergy Y/N

Codeine Y/N

Allergy Y/N

Latex Y/N

Allergy Y/N

Local Anesthetic Y/N

Allergy Y/N

Penicillin Y/N

Allergy Y/N

Sulfa Y/N

List any other allergies: Y/N

Abnormal (High/Low) Blood Pressure Y/N

AIDS/HIV Y/N

Anemia / Bleeding Problems Y/N

Artificial Heart Valves Y/N

Blood Disease Y/N

Congenital Heart Lesions Y/N

Heart Problems Y/N

Pacemaker Y/N

Arthritis / Rheumatism / Gout Y/N

Artificial Joints / Bones Y/N

Asthma Y/N

Cancer Y/N

Chemotherapy Y/N

Diabetes Y/N

Emphysema Y/N

Glaucoma Y/N

Radiation Treatment (X-Ray/Cobalt) Y/N

Shortness of Breath (Breathing Problems) Y/N

Sinus Trouble Y/N

Stroke Y/N

Thyroid Problems Y/N

Tuberculosis Y/N

Tumor / growth on head / neck Y/N

Ulcer Y/N

Epilepsy Y/N

Fainting / Dizziness Y/N

Headaches (Frequent) Y/N

Hepatitis Y/N

Herpes Y/N

Kidney Disease Y/N

Liver Disease Y/N

Nervous Problems Y/N

Psychiatric Care

List any other medical issues you have _____

List any serious illnesses / surgeries / hospitalizations _____

List any medications you are taking _____

Pregnant **Y/N**

Nursing Y/N