MEDICAL HISTORY

Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Rheumatic Fever Yes Nanaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Rheumatism Yes Nanemia Yes No Easily Winded Yes No Herpes Yes No Scarlet Fever Yes Nangina Yes No Emphysema Yes No High Blood Pressure Yes No Shingles Yes No Arthritis/Gout Yes No Emphysema Yes No High Blood Pressure Yes No Shingles Yes No Arthritis/Gout Yes No Emphysema Yes No High Blood Pressure Yes No Shingles Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hives or Rash Yes No Sickle Cell Disease Yes No Arthriticial Ideart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis Yes No Frequent Cough Yes No Hives or Rash Yes No Spina Bifdad Yes No Asthma Yes No Frequent Cough Yes No Kidney Problems Yes No Stomach/Intestinal Disease Yes No Blood Disease Yes No Frequent Diarrhea Yes No Leukemia Yes No Stroke Yes No Broathing Problems Yes No Frequent Headaches Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Bratis Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes No Chemotherapy Yes No Hay Fever Yes No Parathyroid Disease Yes No Tuberculosis Yes No Chest Pains Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes No Venereal Disease Yes No Congenital Heart Disorder Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Venereal Disease Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Osteoporosis Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Osteoporosis Yes No Community Yes No Hay Fever Yes No Recent Weight Loss Yes No Osteoporosis Yes No Norwellow Junualice Yes No Have Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Osteoporosis Yes No Norwellow Junualice Yes No Down Junualice Yes No Hay Fever Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Osteoporosis Yes No Down Junualice Yes No Down Junualice Yes N	Patient Name								Birth Date				
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Have you ever been hospitalized or had a major operation? Yes No			_										
Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken. Phen-Pen or Redux? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No If yes, please explain: Women: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Women: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain: Do you need to pre-medicate? Yes No If yes, please explain: Women: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain: Women: Are you allergic to any of the following? Day in Penicillin Dicodeine Dacrylic Metal Clatex Dlocal Anesthetics (Epinephrine) DSulfa Drugs DOYUN you have, or have you had, any of the following? DS/HIV Positive Yes No Diabetes Yes No Henophilia Yes No Renal Dialysis Yes No Administry Yes No Henophilia Yes No Renal Dialysis Yes No Henophilia Yes No Binghilia Yes No Binghysman Yes No Henophilia Yes No Henophilia Yes No Renal Dialysis Yes No Henophilia Y		-	_	-									
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