

MEDICAL HISTORY

Name _____ Date of Birth _____ Date ____/____/____

Are you Allergic to any medications? No Yes (Please List)

Are you allergic to tape or bandaids? No Yes (Please List) _____

Are you allergic to any numbing medications or dental anesthesia? No Yes (Please List) _____

Please List any other Allergies _____

*PLEASE HAVE YOUR LIST OF MEDICATIONS AVAILABLE FOR THE NURSE WHEN ASKED

Do you or have you ever had diseases or conditions of: (please circle)

Lungs

History of Tuberculosis

Emphysema

Asthma

Chronic Cough

Vascular

High Blood Pressure

Chest Pain

Heart Attack

Heart Murmur

Heart Valve Prolapse

Irregular Heartbeat

Pacemaker / Defibrillator

Phlebitis

Bleeding Disorder

Other Systemic

Alzheimers/Dementia

Diabetes

Thyroid

Kidney

Bladder

Stomach

Bowel

Hepatitis or Jaundice

Glaucoma

Arthritis / Joint Deformity

Convulsions, Epilepsy or Seizures

Fainting

Lupus

Cancer (what type) _____

Fibromyalgia

Sexually Transmitted Disease

Other _____

Please answer the following questions:

Do you drink alcohol?	YES	NO	If YES,	drinks per day?
Do you use IV drugs?	YES	NO	If YES, what?	How much?
Have you had or have you been exposed to HIV (AIDS)?	YES	NO		
Do you smoke?	YES	NO	If YES, how much?	
Are you pregnant?	YES	NO	Due Date:	
Do you have artificial joint(s)?	YES	NO		
Do you have a Hearing Aid or impaired hearing?	YES	NO		
Are you required to take antibiotics before minor surgery?	YES	NO		
Have you ever had skin cancer?	YES	NO	Type:	Location:
Has anyone in your family had skin cancer?	YES	NO	If YES, who?	
Have you had any skin diseases?	YES	NO		

please list: _____

List type and dates of previous surgeries you have had: _____

What are your hobbies? _____

Signed by Physician

Date