

Medical History/Update

Today's Date _____

General Health Excellent Good Fair Poor

Are you presently under the care of a physician?..... Yes No

For what? _____

Have you had an operation, illness or hospitalization in the last year?..... Yes No

Please explain _____

Are you taking any medications, drugs or pills?..... Yes No

Which medications? How much? How often? _____

Are you taking birth control pills?..... Yes No Is there a chance you may be pregnant?..... Yes No

Are you allergic to local anesthetic, penicillin, codeine or any other drugs or substances?..... Yes No

Please list allergies _____

Do you use tobacco? (cigarettes, cigars, pipe, chew) (Please circle)..... Yes No

How much _____ How often _____

Have you had any of the following? Please circle your answer.

- | | | | | |
|-------------------|----------------------|-----------------------------|----------------------|---------------------|
| Abnormal Bleeding | Cancer | Epilepsy | High Blood Pressure | Shingles |
| Alcohol Abuse | Chemo / Radiation | Fainting Spells | Kidney Problems | Sickle Cell Disease |
| Allergies | Colitis | Fever Blisters / Cold Sores | Liver Disease | Sinus Problems |
| Anemia | Congenital Heart | Frequent Headaches | Low Blood Pressure | Stroke |
| Arthritis | Cosmetic Surgery | Glaucoma | Mitral Valve | Thyroid Problems |
| Artificial Bones | Diabetes | HIV / AIDS | Pace Maker | Tuberculosis |
| Artificial Heart | Difficulty Breathing | Hay Fever | Psychiatric Problems | Tumor History |
| Asthma | Drastic Weight Loss | Heart Disease | Radiation Therapy | Ulcers |
| Blood Transfusion | Drug Abuse | Heart Murmur | Rheumatic Fever | Veneral Disease |
| Bruise Easily | Emphysema | Hepatitis Type _____ | Seizures | Yellow Jaundice |

Is there any other medical information you think we should know about that may affect treatment in any way? Yes No

Please explain _____

To the best of my knowledge, I hereby certify the above information is accurate and true.

Patient or Responsible Party _____ Date _____

Date					
BP					

M.D. Referral To Whom _____ Why _____

Medical Alert: