

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: