

PATIENT MEDICAL HISTORY

Patient Name: _____

Please list any medications you are currently taking: _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa or
 Other (please list) _____

Do you have, or have you had, any of the following:

AIDS / HIV Positive

Alzheimer's Disease

Anaphylaxis

Anemia

Angina

Arthritis / Gout

Artificial Heart Valve*

Artificial Joint / Limb*

Asthma

Blood Disease

Blood Transfusion

Breathing Problems

Bruise Easily

Cancer

Chemotherapy

Chest Pains

Cold Sore/Fever Blister

Congenital Heart Disorder

Convulsions

Cortisone Medicine

Diabetes

Drug Addiction

Easily Winded

Emphysema

Epilepsy/Seizures

Excessive Bleeding

Excessive Thirst

Fainting Spells

Frequent Cough

Frequent Diarrhea

Frequent Headaches

Genital Herpes

Glaucoma

Hay Fever

Heart Attack/Failure

Heart Murmur*

Heart Trouble / Disease

Hemophilia

Please Continue on Back

- Hepatitis A
- Hemophilia
- Leukemia
- Hepatitis B or C
- Herpes
- High Blood Pressure
- Hives or Rash
- Hypoglycemia
- Irregular Heartbeat
- Jaundice
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease

- Mitral Valve Prolapse*
- Pain in jaw joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Sinus Trouble
- Spina Bifida
- Stomach/Intestinal Disease

- Stroke
- Swelling of Limbs
- Thyroid Disease
- Tonsillitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Venereal Disease
- Yellow Jaundice

****Condition may require Medication***

Women: Are you pregnant?

Please mark accordingly.

Pregnant

Nursing

Have you ever had any serious illness not listed above? _____

Comments: _____