MEDICAL HISTORY

P/	ATIENT NAME			Birth Date			
-	ion that you may be ta					Health problems that you . Thank you for answeri	-
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: If yes, please explain: If yes, please explain: If yes, please explain:			
Women: Are you Pregnant/Trying	Do you use co	Do you use tobacco? (ntrolled substances? (Yes () No Takir) Yes 🔿 No	otives? 🔿 Yes 🔿 N	o Nursing?	◯ Yes ◯ No	
Aspirin	to any of the following Penicillin [s, please explain:		Acrylic	Metal 🗌 Latex	Local	Anesthetics	
AIDS/HIV Positive Alzheimer's Diseas Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever E Congenital Heart D Convulsions	Yes No Yes No	he following? Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizzine Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease	 Yes ○ No 	Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapss Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatment Recent Weight Loss	Yes No Yes No	Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disea Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	 Yes No
Comments:							
		It is my responsibility to				incorrect information ca is.	

_____ DATE _____