

**MEDICAL HISTORY FORM**

Vital Signs: Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone# \_\_\_\_\_

Date of last visit \_\_\_\_\_ Purpose \_\_\_\_\_

Your current health is:      Good                  Fair                  Poor

Do you smoke or use tobacco in any form? \_\_\_\_\_ Amount \_\_\_\_\_ per day

Are you currently under the care of a physician? \_\_\_\_\_ Please explain \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ Please list below (this is important in which anesthetics we may administer. Please include any over the counter herbal products.)

Name _____	Amount _____	Reason _____
Name _____	Amount _____	Reason _____
Name _____	Amount _____	Reason _____
Name _____	Amount _____	Reason _____
Name _____	Amount _____	Reason _____

**For Women**

Are you taking any birth control pills? \_\_\_\_\_  
 Are you pregnant? \_\_\_\_\_ # of weeks \_\_\_\_\_ Are you nursing? \_\_\_\_\_

Are you allergic to or have you experienced an adverse reaction to any medication or anesthetic?.....	Y	N	Kidney disease?.....	Y	N
Do you have a heart murmur?.....	Y	N	Diabetes?.....	Y	N
Do you drink alcohol?.....	Y	N	Thyroid disease?.....	Y	N
Do you use recreational drugs?.....	Y	N	Stomach ulcers or problems?.....	Y	N
Have you ever had surgery?.....	Y	N	Do you have migraines?.....	Y	N
<b>Do you or have you had:</b>			Any disease, drug or transplant operation that has compromised your immune system?.....	Y	N
Cardiovascular disease (heart trouble, heart attack, angina, pacemaker, high blood pressure, stroke?)..	Y	N	Glaucoma?.....	Y	N
Lung disease (asthma, emphysema, bronchitis, tuberculosis, chronic cough?).....	Y	N	Implants placed anywhere in your body?.....	Y	N
Neuro or psychological disorders (seizures, fainting, psychiatric treatment?).....	Y	N	Radiation Therapy?.....	Y	N
Liver disease (hepatitis, jaundice?).....	Y	N			
Prolonged bleeding?.....	Y	N			

<b>Do you or have you ever taken:</b>	Steroids	Y	N	High blood pressure medications	Y	N
	Nitroglycerin	Y	N	Phen-phen or other diet pills	Y	N
	Digitalis	Y	N			

<b>Are you allergic to any of the following?</b>	Aspirin	Y	N	Dental Anesthetics	Y	N
	Codeine	Y	N	Erythromycin	Y	N
	Penicillin	Y	N	Tetracycline	Y	N
	Latex	Y	N			

Any other drug allergies? \_\_\_\_\_ Please turn page over----->