Past Medical History

Patient: _____ DOB: _____

Please indicate whether you have had any of the following conditions:

Heart Disease or Attack ---------- Yes____No____
Rheumatic Fever ---------- Yes____No____
High Blood Pressure ---------- Yes____No____
Stroke ---------- Yes____No____
Epilepsy or Convulsions ---------- Yes____No____
Diabetes ---------- Yes____No____
Tumor or Cancer ---------- Yes____No____
Respiratory Disease ---------- Yes____No____
Pneumonia or Emphysema ---------- Yes____No____
Tuberculosis ---------- Yes____No____
Asthma ---------- Yes____No____
Hepatitis ---------- Yes____No____
Peptic Ulcer or Pancreatitis---------- Yes____No____
Anemia or other Blood Disorders---------- Yes____No____
Bleeding Disorders---------- Yes____No____
Hernia---------- Yes____No____
Thyroid Disease---------- Yes____No____
Veneral Disease---------- Yes____No____
Congenital Abnormalities---------- Yes____No____
Are you Pregnant ---------- Yes____No____
Do you have a Pacemaker ---------- Yes____No____
Do you have any Surgical Implants ---------- Yes___No_____
Are you a Smoker ---------- Yes____No____

Allergies

Please include ALL Allergies:

Penicillin or other Antibiotics ---------- Yes ____No____
Morphine, Codeine, or other Narcotics ---------- Yes ____No____
Novocaine, or other local Anesthetics ---------- Yes ____No____
Please list other Substances_____

Family History

Cancer---------- Yes ____No____
Heart Disease---------- Yes ____No____
Arthritis---------- Yes ____No____
Tuberculosis---------- Yes ____No____
High Blood Pressure ---------- Yes ____No____
Bleeding Tendency---------- Yes ____No____
Diabetes---------- Yes ____No____
Stroke---------- Yes ____No____
Gout---------- Yes ____No____

List Previous Surgeries:

_____

_____

List Current Medications:

_____

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