

Name _____ Occupation _____

Family Physician _____ Marital Status: S M D W Age _____

Family Dentist _____

Date of your last medical check-up: _____ Are you under physician's care now? _____

If so, what for? _____

FOR OFFICE USE

HT. _____ WT. _____ SEX _____ AGE _____ BP _____ PULSE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

	YES	NO		YES	NO
Rheumatic fever, rheumatic heart disease	<input type="radio"/>	<input type="radio"/>	Radiation treatment for a tumor or other growth	<input type="radio"/>	<input type="radio"/>
Murmurs, heart valve disease	<input type="radio"/>	<input type="radio"/>	STD, HIV, AIDS	<input type="radio"/>	<input type="radio"/>
Heart disease, heart attack	<input type="radio"/>	<input type="radio"/>	Substance abuse (alcohol, cocaine, marijuana, etc.)	<input type="radio"/>	<input type="radio"/>
High blood pressure, low blood pressure	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Chest pain, shortness of breath, swollen ankles	<input type="radio"/>	<input type="radio"/>	Women: Are you pregnant?	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Do you have any sensitivities or allergies to		
Blood disorders, anemia, blood test with unusual results	<input type="radio"/>	<input type="radio"/>	any medications?	<input type="radio"/>	<input type="radio"/>
Abnormal bleeding, prolong healing, bruises easily	<input type="radio"/>	<input type="radio"/>	If yes, please list _____		
Seizures, fainting spells, stroke	<input type="radio"/>	<input type="radio"/>	_____		
Liver diseases, hepatitis, jaundice	<input type="radio"/>	<input type="radio"/>	Do you have any disease, condition, or problem that you		
Kidney disease, stones	<input type="radio"/>	<input type="radio"/>	think the doctor should know about?	<input type="radio"/>	<input type="radio"/>
Tuberculosis, lung ailments, persistent cough, cough up blood	<input type="radio"/>	<input type="radio"/>	If yes, please list _____		
Diabetes	<input type="radio"/>	<input type="radio"/>	_____		

	YES	NO
Have you taken Cortisone, Prednisone or a steroid within the last 2 years? _____	<input type="radio"/>	<input type="radio"/>
Do you regularly take blood thinners? (Aspirin, coumadin, plavix, etc.) _____	<input type="radio"/>	<input type="radio"/>
Are you taking any medicine, drug, or pills for any purpose? _____	<input type="radio"/>	<input type="radio"/>
If so, please list drug, amount and frequency: _____		

Do you have difficulty breathing through your nose? _____	<input type="radio"/>	<input type="radio"/>
Have you ever had hives, wheezing, difficulty breathing following an injection? _____	<input type="radio"/>	<input type="radio"/>
Have you ever had prolonged bleeding following any surgery? _____	<input type="radio"/>	<input type="radio"/>
Do you smoke? _____ Packs per day: _____	<input type="radio"/>	<input type="radio"/>
Do you wear contact lenses? _____	<input type="radio"/>	<input type="radio"/>
Have you ever been put to sleep for a surgical procedure? _____	<input type="radio"/>	<input type="radio"/>
Have you or your relatives had a bad reaction to anesthesia? _____	<input type="radio"/>	<input type="radio"/>
List previous surgeries: _____		
List previous hospitalizations: _____		
General health (circle one): Good Fair Poor		

Patient/Guardian Signature _____ Date _____