





## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                                   |  |                       |  |                          |  |
|-----------------------------------|--|-----------------------|--|--------------------------|--|
| AIDS/HIV                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders                | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |  |
| Ear Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |  |

Surgeries you have had \_\_\_\_\_  
\_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_  
\_\_\_\_\_

Family physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) (\_\_\_\_\_) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

## ALLERGIES

- |  |  |
|--|--|
| <input type="checkbox"/> Adhesive/Tape         | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine         |
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Codeine               | <input type="checkbox"/> Seafoods          |
| <input type="checkbox"/> Demerol               | <input type="checkbox"/> Sulfa             |
| <input type="checkbox"/> Iodine                |  |
| Other _____                                    |  |

## TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient