MEDICAL HISTORY

1. The name, address and phone number of my physician: _____

_____

2. As far as you know, are you in good health? _____ **Yes** ☐ **No** ☐

Do you have, or have you had any of the following:

A. Rheumatic fever or rheumatic heart disease? _____ **Yes** ☐ **No** ☐

B. Congenital heart disease? _____ **Yes** ☐ **No** ☐

C. Cardiovascular disease (heart trouble, heart attack, high blood pressure, low blood pressure, arteriosclerosis, angina, stroke) _____ **Yes** ☐ **No** ☐

D. A Cardiac pacemaker _____ **Yes** ☐ **No** ☐

E. Sinus Trouble _____ **Yes** ☐ **No** ☐

F. Asthma, hey fever _____ **Yes** ☐ **No** ☐

G. Neurological disorder, example (Epilepsy, seizures, fainting) _____ **Yes** ☐ **No** ☐

H. Diabetes _____ **Yes** ☐ **No** ☐

I. Liver Disease, example (Hepatitis or Jaundice) _____ **Yes** ☐ **No** ☐

J. Arthritis _____ **Yes** ☐ **No** ☐

K. Stomach disease example (Ulcers) _____ **Yes** ☐ **No** ☐

L. Intestinal Disease example (Polyps) _____ **Yes** ☐ **No** ☐

M. Kidney Disease _____ **Yes** ☐ **No** ☐

N. Lung Disease example (Tuberculosis, Pneumonia) _____ **Yes** ☐ **No** ☐

O. Veneral disease _____ **Yes** ☐ **No** ☐

P. Blood disease example (Anemia) _____ **Yes** ☐ **No** ☐

Q. Is there someone in your family with diabetes? _____ **Yes** ☐ **No** ☐

R. Following and injury, do you bleed excessibly? _____ **Yes** ☐ **No** ☐

3. Have you been hospitalized for any serious condition? _____ **Yes** ☐ **No** ☐

If yes, for what? _____

4. Are you under the care of a physician? _____ **Yes** ☐ **No** ☐

Are you taking any of the other? _____ **Yes** ☐ **No** ☐

A. Antibiotics or Sulfa _____ **Yes** ☐ **No** ☐

B. Anticoagulants (blood thineers) _____ **Yes** ☐ **No** ☐

C. Medicine for high blood pressure _____ **Yes** ☐ **No** ☐

D. Steroids (cortisone) _____ **Yes** ☐ **No** ☐

E. Tranquilizers _____ **Yes** ☐ **No** ☐

F. Analgesics (pain killers, aspirin and codeine) _____ **Yes** ☐ **No** ☐

G. Antihistamines _____ **Yes** ☐ **No** ☐

H. Insulin, Orinase _____ **Yes** ☐ **No** ☐

I. Digitalis or drugs for hear trouble _____ **Yes** ☐ **No** ☐

J. Nitroglycerin _____ **Yes** ☐ **No** ☐

K. Sedatives (sleeping pills, barbiturates) _____ **Yes** ☐ **No** ☐

L. Any others _____ **Yes** ☐ **No** ☐

5. Are you allergic or have you had any allergic reaction to: _____ **Yes** ☐ **No** ☐

A. Local anesthetics _____ **Yes** ☐ **No** ☐

B. Penicillin or other antibiotics _____ **Yes** ☐ **No** ☐

C. Sulfas _____ **Yes** ☐ **No** ☐

D. Sedatives (sleeping pills, barbiturates) _____ **Yes** ☐ **No** ☐

E. Aspirin _____ **Yes** ☐ **No** ☐

F. Codeine or other narcotives _____ **Yes** ☐ **No** ☐

G. Any other allergic reactions? _____ **Yes** ☐ **No** ☐

6. Have you been exposed to radiation recently? _____ **Yes** ☐ **No** ☐

7. If FEMALE are you pregnant? How many months? _____ **Yes** ☐ **No** ☐

_____ _____

Patient signature **Date**

or (Legal guardian if patient is under age of 18)