

**Medical History**

Primary Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please Circle Yes or No to the following Questions:

Have you ever had a serious illness or operation in the past 5 years? ……………………………….Yes No

If yes, Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any Medications? ……………………………………………………………………Yes No

If yes, List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a heart mummer or rheumatic heart disease? ………………………………………… Yes No

Do you have an artificial valve, pacemaker, or heart trouble? ………………………………………Yes No

Do you have artificial knee\_\_\_, hip\_\_\_\_, or shoulder \_\_\_\_\_\_\_ replacements? …………………….Yes No

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

 High Blood Pressure? ................................................................................................................ Yes No

 Diabetes? ....................................................................................................................................Yes No

 Hepatitis, Jaundice, or Liver Problems? ……………………………………………….………Yes No

 AIDS, HIV Infection or Problems of the Immune System? ……………………………….......Yes No

 Thyroid or Kidney Problems? …………………………………………………………………Yes No

 Epilepsy or Other Neurological problems? …………………………………………….……...Yes No

 Cancer or Treatment for Tumors? ……………………………………………………………..Yes No

 Abnormal Bleeding? ………………………………………………………………….……….Yes No

 Asthma? ……………………………………………………………………………………….Yes No

 Do you Smoke? …………………………….………………………………………………….Yes No

 Have you had any serious trouble with dental treatment? …………………………………….Yes No

 Are there any medical conditions not listed above that should be disclosed………….……….Yes No

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (Circle)**

Local Anesthetics **Penicillin** or other antibiotics **Latex**

Aspirin Codeine or other Narcotics Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women**

 Are you pregnant? …………………………………………………….……………………….Yes No

 Are you taking birth Control Pills………..…………………………………………………….Yes No