MEDICAL HISTORY

Patient's Name:_______________________________________ **Date:**_________________

Family Physician:_______________________ _______________ **Physician's Address:**__________________________________

	YES	NO	ARE YOU ALLERGIC OR REACTED ADVERSELY TO:	YES	NO
Do you test positive for the AIDS virus (HIV positive) or have AIDS related complex?			Local Anesthetics (ex:Novacaine)		
Any changes in your general health in the last year?			Penicillin (or other antibiotics)		
Are you being treated presently by a physician?			Sulfa Drugs		
Are you taking any drugs/medications now?			Barbituates, Sedatives, Sleeping pills		
Do you have any allergies?			Aspirin		
Do you bleed easily or of long duration?			Codiene or other narcotics		
Do you bruise easily?			Any other known drug allergies		
Have you ever been diagnoses with a heart murmur?			Latex		
Have you had any joint or heart valve replacements?			**WOMEN**: Are you pregnant ?		
Have you ever had Rheumatic Fever?					
Do you take any blood thinners?					

Have you had any of the following?	Yes	No		Yes	No		Yes	No
Any serious illness			Hepatitis			Tuberculosis		
Operations			Jaundice			Cancer or tumors		
High Blood Pressure			Anemia			Venereal Disease		
Low Blood Pressure			Stomach Ulcers			Arthritis		
Diabetes			Glaucoma			Blood Transfusions		

Have you ever experienced any of the following?	Yes	No		Yes	No		Yes	No
Severe Coughing Spells			Chest Pains			Easy Fatigue		
Frequent Severe Headaches			Swelling Ankles			Dizzy Spells		
Difficulty in Breathing			Swollen Joints			Skin Rashes		
Shortness of Breath			Painful Urination			Convulsions		
Frequent Indigestion			Blood in Urine					

Please list any/all medications that you are presently taking:____

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Patient/Guardian Signature____ Date___________________

DO NOT WRITE IN THIS AREA—FOR OFFICE USE ONLY

DOCTOR'S SIGNATURE____________________________________ **DATE**___________________________