Medical History

Y	N	ASTHMA	Y	N	KIDNEY PROBLEMS
Y	N	HAY FEVER	Y	N	LIVER PROBLEMS
Y	N	BLOOD PRESSURE-HIGH/LOW	Y	N	HIV
Y	N	HEART ATTACK/ STROKE	Y	N	SINUS PROBLEMS
Y	N	HEART SURG/PACEMAKER	Y	N	ULCERS PROBLEMS
Y	N	HEART MURMUR	Y	N	VENEREAL DISEASE
Y	N	PHEUMATIC FEVER	Y	N	ALCOHOL/ DRUG ABUSE
Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS
Y	N	ARTIFICIAL VALVES	Y	N	HEPATITIS
Y	N	HEART DISEASE	Y	N	ARTHRITIS /RHEUMATISM
Y	N	CANCER/ TUMORS	Y	N	X-RAY OR COBALT TREATMENT
Y	N	ARTIFICIAL BONES/ JOINT	Y	N	LEUKEMIA
Y	N	CHEMOTHERAPY	Y	N	ANEMIA
Y	N	DIABETES	Y	N	BLEEDING OR CLOTTING DISORDERS
Y	N	NERVOUSNESS/ EPILEPSY	Y	N	THYROID PROBLEMS

Are you **presently taking any medicine**? Specify: _____
_____
_____
_____

Please list any **other Surgeries** or medical conditions you have ever had: _____
_____

Are you allergic to any of the following?

LATEX PENICILLIN/AMOXICILLIN TETRACYCLINE ASPIRIN

DENTAL ANESTHETICS OTHERS _____

FOR WOMEN: Are you taking birth control? Y N
Are you Pregnant? Y N
Are you nursing? Y N

SIGNATURE PATIENT _____ DATE ____/___/____

SIGNATURE DOCTOR_____ DATE ____/___/____

UPDATE SIGNATURE _____ DATE ____/___/____

SIGNATURE _____ DATE ____/___/____