MEDICAL HISTORY

Are you in good health now? Y N If no, please explain: ______________________________

____

Have you recently, or are you presently, taking any prescriptions or non-prescription drugs incl. health remedies? Y N
If Yes, please list: ____

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Have you ever reacted adversely to any medications or injections?
Penicillin Codeine Local Anesthetic Sulpha Drugs Aspirin Other

Have you ever been advised against taking any specific type of medication? Y N

Do you have any of the following? (please circle):
Asthma Hay Fever Food Allergies Metal Allergies Latex Allergies Skin Rashes Hives Other

Do you bleed excessively from a cut or injury? Y N Do you bruise easily? Y N

Have you tested HIV positive? Y N Do you smoke? Y N

Are you alcohol and/or drug dependent? Y N

Indicate which of the following you presently have or ever had (please circle):

AIDS Anemia Angina pectoris Arthritis/rheumatism Artificial joints (hip knee) Blood disorders
Bronchitis Cancer Circulation problems Congenital heart lesions Cortisone/steroid Crohn's disease
Diabetes Emphysema Epilepsy or seizures Fainting or dizzy spells Glandular disorders Glaucoma
Head/neck injuries Heart disease or attack Heart murmur Heart pacemaker Heart rhythm disorder
Hepatitis A Hepatitis B Hepatitis C Herpes High blood pressure Low blood pressure
Hodgkins disease Hyper glycemia Hypertension Inflammatory bowel disease Jaundice Kidney disease
Liver disease Lung disease Lupus Malignant hyperthermia Mental/nervous disorder
Mitral valve prolapse Organ transplant Psychiatric treatment Radiation treatment/chemotherapy
Scarlet fever Rheumatic fever Sickle cell disease Sinus trouble Stomach/intestinal problems/ulcers
Stroke Thyroid disease Tuberculosis Venereal disease Measles Mumps Chicken Pox
Strep throat Tonsillitis Cold Sores

Do you currently have, or have you had in the past, any disease, condition or problem not listed above? Y N

If Yes, please explain: ____

Is there anything else about your health we should be aware of? Y N

If Yes, please explain: ____

Women Only (please circle): N/A

Are you pregnant? Due Date: ______________ Are you breast feeding? Are you taking any birth control pills?