Are you in good health now? Yes No

**MEDICAL HEALTH HISTORY**

Are you now under the care of a physician? Yes No

* If so, what is the condition being treated?

Have you ever been hospitalized or had a serious illness? Yes No

* If yes, please explain

Have you ever had excessive bleeding with an extraction or do cuts take longer to heal? Yes No

Are you pregnant?

* If so, please give your due date Yes No

Do you have more than 2 alcoholic beverages a day? Yes No

***Have you ever had any of the following?***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL** |  |  | **Respiratory** |  |  | **DIGESTIVE SYSTEM** |  |  |
| Tire Easily/Weakness | Yes | No | Tuberculosis | Yes | No | Hepatitis | Yes | No |
| Marked Weight Change | Yes | No | Asthma/Hay Fever | Yes | No | Jaundices | Yes | No |
| Night Sweats | Yes | No | Persistent Cough | Yes | No | Ulcers | Yes | No |
| Persistent Fever | Yes | No | Sputum Production | Yes | No | Change in Appetite | Yes | No |
| **SKIN** |  |  | Coughing Blood | Yes | No | Black, Bloody or Pale Stools | Yes | No |
| Eruptions, Rash, Hives | Yes | No | Difficulty Breathing | Yes | No | **URINARY** |  |  |
| Change In Skin Color | Yes | No | **endocrine** |  |  | Kidney Disease | Yes | No |
| **EYES** |  |  | Diabetes | Yes | No | Night Urinary Increase | Yes | No |
| Visual Changes | Yes | No | Family History of Diabetes | Yes | No | Burning when Urinating | Yes | No |
| Glaucoma | Yes | No | Thyroid Condition/Goiter | Yes | No | Urethral Discharge | Yes | No |
| **EARS** |  |  | Other | Yes | No | Bloody Urine | Yes | No |
| Loss of Hearing | Yes | No | **Heart/Blood Vessels** |  |  | Venereal Disease | Yes | No |
| Ringing in Ears | Yes | No | Rheumatic Fever | Yes | No | **BLOOD** |  |  |
| **NOSE** |  |  | Heart Murmur | Yes | No | Bruise Easily | Yes | No |
| Frequent Nose Bleeds | Yes | No | Chest Pain/Discomfort | Yes | No | Anemia | Yes | No |
| Sinus Problems | Yes | No | Heart Attack/Trouble | Yes | No | Blood Transfusion | Yes | No |
| **Throat** |  |  | Shortness of Breath | Yes | No | **OTHER** |  |  |
| Soreness/Hoarseness | Yes | No | Swelling of Ankles | Yes | No | Latex Sensitivity | Yes | No |
| **Nervous System** |  |  | High Blood Pressure | Yes | No | Radiation Therapy | Yes | No |
| Stroke | Yes | No | Congenital Heart Disease | Yes | No | Chemotherapy | Yes | No |
| Headaches | Yes | No | Mitral Valve Prolapse | Yes | No | Tumors/Growths | Yes | No |
| Convulsions/Epilepsy | Yes | No | Artificial Heart Valve | Yes | No | Cancer | Yes | No |
| Dizziness/Fainting | Yes | No | Pacemaker | Yes | No | HIV | Yes | No |
| Psychiatric Treatment | Yes | No | Heart Surgery | Yes | No | AIDS | Yes | No |
| **BONE/MUSCLES** |  |  | Other | Yes | No |  |  |  |
| Arthritis/Rheumatism | Yes | No |  |  |  |  |  |  |
| Artificial Joints/Limbs | Yes | No |  |  |  |  |  |  |

**Please list all medications you are currently taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ALLERGIES** |  |  | **PRESCRIPTIONS** |  |  | Antihistamines/Allergy Drugs | Yes | No |
| Local Anesthetics/Novocain | Yes | No | Antibiotics | Yes | No | Tranquilizers | Yes | No |
| Barbiturates/Sedatives | Yes | No | Blood Thinners | Yes | No | Insulin/Diabetes Drugs | Yes | No |
| Penicillin/Other Antibiotics | Yes | No | Blood Pressure Medications | Yes | No | Digitalis/Heart Medications | Yes | No |
| Aspirin | Yes | No | Thyroid Medication | Yes | No | Nitroglycerin | Yes | No |
| Other Allergies | Yes | No | Cortisone/Steroids | Yes | No | Aspirin | Yes | No |

The preceding answers are true and correct\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_