Past Medical History

Name ______________________________________ Sex ______ Date ________________

Age ________ Race ________ Height ________ Weight ________

Occupation __________________________________ Shoe Size ______________

Family Physician ______________________________ Phone _________________________

Personal History

( ) Diabetes	( ) Seizure Disorders	( ) Arthritis
( ) Heart Trouble	( ) Bleeding Disorders	( ) Asthma
( ) Circulatory Disease	( ) Hypertension (High B/P)	( ) Epilepsy
( ) Kidney Trouble	( ) Hypotension (Low B/P)	( ) Hepatitis
( ) Rheumatic Fever	( ) Nervous Condition	( ) Stroke
( ) Stomach Ulcers	( ) Sickle Cell Anemia	( ) Gout
( ) Skin Problems	( ) Liver Disease	( ) High Cholesterol
( ) Depression	( ) Anxiety Disorder	( ) Thyroid Problem

Allergies

( ) Foods	( ) Sulphur/Sulphites	( ) Iodine
( ) Aspirin	( ) Environmental	( ) Tape
( ) Codeine	( ) Local Anesthesia	( ) Other
( ) Penicillin	( ) Novocain	

Past Surgical History:

Surgery	Date	Surgery	Date
________________	_________	____________________	__________
________________	_________	____________________	__________
________________	_________	____________________	__________

Present Medications Please list medication and what illness medication is prescribed for

Medications	Illness	Medication	Illness
________________	_________	____________________	__________
________________	_________	____________________	__________
________________	_________	____________________	__________

Family History (Parents, Grandparents, Brothers, Sisters)

( ) Diabetes	( ) Hypertension	( ) Bleeding Disorder
( ) Circulatory	( ) Arthritis	( ) Problem with Anesthesia

Social History:

Tobacco (Pks/Day) ____________ Coffee/Tea (Cups) ________ Alcohol ____________

Do you take aspirin regularly _____ Do you faint easily? _______