

Patient's Medical History

Patient's Name _____ Date of Birth _____ SSN _____

Please complete the following to the best of your knowledge:

Are you in good health generally? YES / NO
 Do you take aspirin, or products which contain aspirin? YES / NO

ALLERGIES:

Are you sensitive or allergic to:

* Penicillin	YES / NO
* Codeine	YES / NO
* Sulfa	YES / NO
* Lidocaine Anesthetic	YES / NO

* Please list any other drugs you may be allergic to: _____

MEDICATIONS:

Are you taking any prescription medications? YES / NO

If yes, please list: _____

HISTORY:

Do you have a personal history of:

Asthma	YES / NO	Blood Disease	Type _____	YES / NO
Diabetes	YES / NO	Emotional Disorder		YES / NO
Glaucoma	YES / NO	Heart Trouble		YES / NO
Hepatitis	Type _____	HIV Exposure		YES / NO
High Blood Pressure	YES / NO	Kidney Problems		YES / NO
Peptic Ulcer	YES / NO	Rheumatic Fever		YES / NO
Tuberculosis	YES / NO	Lung Disease	Type _____	YES / NO
Melanoma	YES / NO	Liver Disease	Type _____	YES / NO

Have you ever had major surgery? YES / NO

Please list with approximate dates: _____

Personal social history:

Do you drink alcohol? YES / NO If yes, number of drinks/day? _____
 Do you smoke cigarettes? YES / NO If yes, number of packs per day? _____

WOMEN:

Are you pregnant or nursing? YES / NO

Patient or Guardian's Signature

Date