Medical History

Name:____

		Yes	No
1.)	Have you ever been hospitalized, major operations or serious illness?...	Yes	No
	If so what?____		
2.)	Are you under any medical treatment now?..	Yes	No
3.)	Have you had any allergic reactions to any drugs (penicillin, codeine, novocaine, aspirin)?...........	Yes	No
4.)	Has there been any change in your health in the past year?...	Yes	No
5.)	Have you ever had a blood transfusion? …………………………………………………………...	Yes	No
6.)	Have you ever had kidney dialysis treatment?...	Yes	No
7.)	Have you ever had abnormal bleeding problems after a cut or tooth extraction?.............................	Yes	No
8.)	Are you taking drugs or medications?...	Yes	No
	If so what?____		

9.) Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment………………………………	Yes	No	Liver Disease………………………………	Yes	No
High Blood Pressure……………………….	Yes	No	Venereal Disease…………………………..	Yes	No
Rheumatic Fever ………………………….	Yes	No	AIDS……………………………………….	Yes	No
Heart Murmur……………………………..	Yes	No	Stomach or Intestinal Disease……………..	Yes	No
Mitral Valve Prolapse……………………..	Yes	No	Kidney Disease …………………………..	Yes	No
Angina……………………………………..	Yes	No	Tumors or Growths…………………………	Yes	No
Stroke………………………………………	Yes	No	Diabetes …………………………………….	Yes	No
Blood Disease………………………………	Yes	No	Tuberculosis………………………………...	Yes	No
Hemophilia………………………………….	Yes	No	Respiratory Disease………………………...	Yes	No
Asthma……………………………………..	Yes	No	Epilepsy …………………………………….	Yes	No
Hepatitis or Yellow Jaundice………………	Yes	No			

			Yes	No
10.)	Women:	A. Are you Pregnant…………………….	Yes	No
		B. Estimated Date of Delivery____________________________		

Signature:____ Date:_______________________

Updates/Notes:____