TELL US ABOUT YOUR HEALTH:

PRINT YOUR NAME:_____

When was your last physical exam?_____ **How is your Health?** ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

Primary Physician:_____ Address:_____ _____ Phone:_____ FAX:_____	Specialty:_____ Dr. _____ Address:_____ Phone:_____ FAX_____	Specialty:_____ Dr. _____ Address:_____ Phone:_____ FAX_____

Have you ever had any kind of surgery?……No ☐ Yes ☐

If yes, what kind?
1._____Date _____ 4._____Date _____
2. _____ Date _____ 5._____Date _____
3._____ Date _____ 6._____ Date _____

Have you ever had any trouble with prolonged bleeding after surgery?……... No ☐ Yes ☐
Are you on blood thinner medication…….…….…. No ☐ Yes ☐
Do you wear a pacemaker or any other kind of prosthetic device?…….. No ☐ Yes ☐
Are you taking any kind of medication, drugs (including marijuana), or herbals at this time?.....No ☐ Yes ☐

***__If yes__ please give name(s) of the medicine(s), drug(s) herbals, and reason(s) for taking them.

Name of MEDICATION	**Reason** for Med

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Do you have __MEDICATION__, Latex or any other Allergies?.....No ☐ Yes ☐
If yes, allergic to: ☐ Aspirin ☐ Local Anesthetic ☐ Codeine ☐ Latex ☐ Penicillin ☐ Others_____

If FEMALE, are you pregnant or nursing ……..…….No ☐ Yes ☐
Are you taking birth control pill, patch or shot……..…….……No ☐ Yes ☐

Please circle any past or present illness you have had:

Alcoholism	Blood Pressure	Epilepsy	Hepatitis	Kidney or Liver	Sinusitis
Allergies	Blood Disease	Glaucoma	Herpes	Mental Condition	Stroke
Anemia	Cancer	Head/Neck Injuries	Immunodeficiency	Migraine	Thyroid Condition
Artificial Joint	Diabetes	Heart Condition	Infectious Diseases:	Mitral Valve Prolapse	Ulcers
Asthma	Drug Dependency	Heart Pacemaker	e.g.*HIV,TB, Hepatitis*	Respiratory Condition	Veneral Disease

Do you have any disease not mentioned above?……..…..…..……No ☐ Yes ☐
If __yes__ to above question what is the disease? _____

Is there information about your health that we should know? ……..…..…….No ☐ Yes ☐
If __yes__ to above question what is the information?_____

Comments _____
_____
_____

Signature of Patient, Parent/Guardian_____**Date**_____

*Reviewed by*_____*Date*_____