MEDICAL HISTORY

PLEASE INDICATE IF YOU HAVE EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

____AIDS/HIV
____Allergy to Anesthetics
____Anemia
____Angina
____Arthritis
____Back Problems
____Cancer
____Chemical Dependency
____Chemotherapy
____Chest Pain
____Chronic Diarrhea
____Circulatory Problems
____Diabetes
____Ear Problems
____Epilepsy
____Eye Problems
____Fainting
____Gout
____Headaches
____Heart Disease
____Hemophilia
____Hepatitis/Jaundice
____High Blood Pressure
____Kidney Disease
____Liver Disease
____Low Blood Pressure
____Neuropathy
____Phlebitis
____Psychiatric Care
____Radiation Treatment
____Rash
____Respiratory Disease
____Rheumatic Fever
____Shortness of Breath
____Sinus Problems
____Special Diet
____Stroke
____Swollen Neck Glands
____Tuberculosis
____Ulcer of Foot
____Ulcer of GI tract
____Varicose Veins
____Venereal Disease
____Weight Loss, Unexplained
____Other Condition Not Listed_____
_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (Please check all that apply)

____Adhesive Tape
____Anticoagulant Therapy
____Aspirin
____Codeine
____Iodine
____Local Anesthetics (Novocaine)
____Pain Medication/Narcotics
____Penicillin
____Other Antibiotics_____
____Sulfa
____Other _____

Please list any surgeries you have had:_____

_____

_____

Have you ever been hospitalized other than surgery?_____