Name_____ Today's Date_____

Age_____ Race _____ Sex M F Marital Status M S W D

Height_____ Weight_____

MEDICAL HISTORY: CIRCLE ONE

Serious Illnesses Yes No If yes Explain: _____

Previous Surgery Yes No If yes Explain:_____

Abnormal Bleeding Yes No If yes Explain:_____

Serious Injuries	Yes	No	Abnormal Scarring	Yes	No
Heart Disease	Yes	No	Kidney Disease	Yes	No
Lung Disease	Yes	No	Bladder Problems	Yes	No
Breast Disease	Yes	No	Diabetes	Yes	No
Stomach Problems	Yes	No	Asthma	Yes	No
Bowel Problems	Yes	No	Nervous Disorders	Yes	No
Liver Disease	Yes	No	Fainting Spells	Yes	No
Eye Problems	Yes	No	Are You Pregnant?	Yes	No
Nerve Injury or Paralysis	Yes	No	Last Menstrual Period Date	_____	

If YES to any of the above, please Explain:_____

FAMILY HISTORY: If YES indicate family member:

_____ Heart Disease	_____Diabetes	_____Cancer
_____Abnormal Bleeding	_____Liver Disease	_____Breast Cancer
_____Arthritis	_____Kidney Disease	_____Abnormal Scars

ALLERGIES AND SENSITIVITES: Is there a history of skin or other abnormal reaction or sickness following injection or oral administration of:

	CIRCLE ONE		WHAT?
Penicillin or other antibiotics	Yes	No	_____
Morphine, Codeine, Demerol or other narcotics	Yes	No	_____
Novacaine or other anesthetics	Yes	No	_____
Aspirin, Empirin or other pain remedies	Yes	No	_____
Sulfa drugs	Yes	No	_____
Tetanus other serums	Yes	No	_____
Latex	Yes	No	_____
Adhesive tape	Yes	No	_____
Iodine, Methiolate, Phisohex or other antiseptics	Yes	No	_____
Any other drugs or medications	Yes	No	_____
Any foods, such as egg, milk or sea foods	Yes	No	_____

MEDICINE TAKEN: Within the past six months have you taken:

	CIRCLE ONE			CIRCLE ONE	
Cortisone or other steroids	Yes	No	Tranquilizers	Yes	No
Blood Pressure Medicine	Yes	No	Aspirin	Yes	No
Anticoagulants or other blood thinning medicines	Yes	No	Diabetes Medicine	Yes	No
			Birth Control Pills	Yes	No

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?_____

HABITS: Tobacco _____ Alcohol _____ Recreational Drugs _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? Explain:_____

WHAT ELSE WOULD YOU LIKE US TO KNOW ABOUT YOUR HEALTH?_____