

MEDICAL HISTORY

Height _____ Weight _____

Date of last physical _____ Physician's Name _____

Have you ever had any of the following? (Check those that apply)

AIDS or other immune Disorder	Artificial Heart Valves or Joints	Hepatitis, jaundice, or liver disease
Allergies to Anesthetics	Diabetes	Rheumatic Fever
Arthritis	Respiratory Disease	Sinus Problems
Asthma	Epilepsy	Stroke
Heart Problems	Headaches	Ulcer
High blood pressure	Cancer	Venereal Disease
Low blood pressure	Chronic Diarrhea	Chemical Dependency
Circulatory problems	General Allergies	Swollen Neck Glands
Nervous problems	Blood Disease	Recent Weight Loss
Radiation treatment	Thyroid Problems	

Are you taking any medications at this time?

Name of medication and frequency:

Previous Surgery (Type and Date) _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? If so, what?

Have you ever responded adversely to medical or dental treatment? _____

Are you under the care of a physician? ____ If so, for what conditions? _____

Women: Do you suspect you are pregnant? Yes No Are you nursing? Yes No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment and billing. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that I am responsible for payment of my account the day charges are incurred.

Signature: _____ Date: _____ Rev. 12-30-04