Medical History (Pleas a circle, “Yes” or “No” to indicate if you had any of the following:)

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Rash	Yes	No
Allergies to Anesthetics	Yes	No	Eye Problems	Yes	No	Respiratory	Yes	No
Allergies to Medicine/Drugs	Yes	No	Fainting	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Foot or Leg Cramps	Yes	No	Shortness of Breath	Yes	No
Angina	Yes	No	Gout	Yes	No	Sinus Problems	Yes	No
Arthritis	Yes	No	Headaches	Yes	No	Special Diet	Yes	No
Artificial Heart Valve/Joints	Yes	No	Heart Disease	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Hemophilia	Yes	No	Swelling in Ankles or Feet	Yes	No
Back Problems	Yes	No	Hepatitis or Jaundice	Yes	No	Tired Feet	Yes	No
Bleeding Disorders	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No	Ulcers	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Varicose Veins	Yes	No
Chest Pain	Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No
Chronic Problems	Yes	No	Neuropathy	Yes	No	Weight Loss, Unexplained	Yes	No
Circulatory Problems	Yes	No	Phlebitis	Yes	No			
Diabetes	Yes	No	Psychiatric Care	Yes	No			
Ear Problems	Yes	No	Radiation Treatment	Yes	No			

If you checked yes to Diabetic or Neuropathy: Managing Physician ______________________________Date Last Seen _________

Surgeries you have had____

Hospitalization other than for surgeries listed____

Primary Care Physician ____Last visit date______________________________

Are you now, or have you been, under any other doctor’s care for any reason over the past two years? Yes No

If yes, please explain____

Medications	***Dose***	***Frequency***

Allergies (Please Circle)

Adhesive/Tape
Aspirin
Codeine
Demerol
Iodine
Local Anesthetics
Novocain
Penicillin
Seafoods
Sulfa Other____________________________

____ ______________________________________

Signature of Parent, Guardian or Personal Representative Date

____ ______________________________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient