Medical Information Form

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Height _____ Weight _____ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Asthma	❑	❑	Bleeding tendency	❑	❑	Low blood sugar
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Jaundice / Liver disease	❑	❑	Kidney trouble
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Hepatitis	❑	❑	Are you on dialysis
❑	❑	High blood pressure	❑	❑	Respiratory problems	❑	❑	Infectious mononucleosis	❑	❑	Arthritis / Joint disease
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Gallbladder trouble	❑	❑	Stomach ulcers
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Fainting spells	❑	❑	Contagious diseases
❑	❑	Heart attack(s)	❑	❑	Do you smoke	❑	❑	Convulsions / Epilepsy	❑	❑	Delay in healing
❑	❑	Irregular heart beat	❑	❑	Do you use chewing tobacco	❑	❑	Stroke	❑	❑	Anemia
❑	❑	Cardiac pacemaker	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Heart surgery	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Radiation / Chemotherapy
❑	❑	Bronchitis / Chronic cough	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Are you on a diet
❑	❑	Chronic fatigue / Night sweat	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Contact lenses
❑	❑	Mental health problems	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles	❑	❑	Immune system problems
❑	❑	Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Malignant hyperthermia			
❑	❑	Are you immunosuppressed? (possibly from transplant surg.)	❑	❑	Problems w/ immune system? (possibly from med. / surg.)						

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Have you ever taken diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood thinners (Coumadin, Aspirin, Advil)									
❑	❑	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Sodium pentothal
❑	❑	Valium or other tranquilizers	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Amoxicillin

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date:_____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No