Medical History

Patient Name ______________________________________ Sex ________ Age _________

Please circle 'Yes' or 'No' to the following questions.

1. Please list any medications you are currently taking. ____
2. Have you ever had an allergic reaction to any of the following:
   LATEX **Yes / No** , Local Anesthetic **Yes / No** , Penicillin **Yes / No** **,** Codeine **Yes / No** **,** Aspirin **Yes / No**
3. Do you have any heart problems? **Yes / No** Chest pains? **Yes / No** Angina? **Yes / No**
4. Have you ever had a heart attack? **Yes / No** Have you ever had heart surgery? **Yes / No**
5. Do you have a bleeding problem? **Yes / No** Do you bruise easily? **Yes / No**
6. Have you had any problems with your liver? **Yes / No** Do you have chronic hepatitis? **Yes / No**
7. Have you ever been treated for cancer? **Yes / No** Leukemia? **Yes / No** Lymphoma? **Yes / No**
8. Have you ever had a seizure? **Yes / No** Have you ever had a stroke? **Yes / No**
9. Do you have arthritis? **Yes / No** Rheumatism? **Yes / No** Joint pain? **Yes / No**
10. Do you have asthma? **Yes / No** Any other breathing problems? **Yes / No** ______________________
11. ***Females*** **:** Are you pregnant? **Yes / No** Breast feeding? **Yes / No**

Please check 'Yes' or 'No' to the following questions.

12. Have you had surgery or been hospitalized overnight in the last six months? Yes ______ No ______
    If yes, please explain. ____
13. Do you have high blood pressure? Yes ______ No ______
14. Do you have diabetes? Yes ______ No ______
15. Do you have thyroid problems? Yes ______ No ______
16. Do you have problems with your immune system? Yes ______ No ______
17. Have you ever tested ***positive*** for HIV infection? Yes ______ No ______
18. *Females*: Has patient begun menstruation? (If Yes, when? _________) Yes ______ No ______
19. Do you have any kidney problems? Yes ______ No ______
20. Who is your physician? ____

If you answer *yes* to any of the questions, please explain. ___________________________________
____

_______________________________________ ________________
Signature (parent if patient is a minor) Date