Medical History

Date: 04/26/2023

Last Name: First Name: Birthdate: 01/01/0001

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

Please list all the medication(s) that you're taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes Type: ☐1 ☐2 ☐3			If "YES": Due date: _____ Gender: _____
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	Blood Pressure: ☐High ☐Low	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever
☐	☐	HIV/AIDS	☐	☐	Autoimmune disease
☐	☐	Hepatitis Type: ☐A ☐B ☐C			If "YES", please specify: _____
☐	☐	Surgery: _____			

Other: _____

Tobacco use? If so, what kind and how much? _____

If NOT patient, please print name below:

_____

Signature ☐Parent ☐Legal Guardian ☐Spouse