MEDICAL HEALTH

Name of Physician _____ Phone # _____

Name of any Specialist _____ Phone # _____

Have you been under a physician's care during the last 2 years? _____ For? _____

Have you been treated in the hospital in the last 2 years? _____ For? _____

Have you ever had major surgery? _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you had a blood test for hepatitis? _____ Were you vaccinated for hepatitis? _____

Have you had cankers/cold sores on your lips/tongue/body? _____

Are you now or have you taken any prescription drug in the past year? _____ For? _____

Are you allergic to Penicillin ☐ Codeine ☐ Local Anaesthetics ☐ Metal ☐ Latex ☐ Other? _____

Have you had or do you have:

Yes	No		Yes	No		Yes	No	
☐	☐	Blood Disorders	☐	☐	Emphysema	☐	☐	Liver Disease
☐	☐	Anemia	☐	☐	Asthma/Hay Fever	☐	☐	Cirrhosis of the Liver
☐	☐	Hemophilia	☐	☐	Pneumonia/Pleurisy	☐	☐	Hepatitis A
☐	☐	Bleeding Easily	☐	☐	Breathing Disorders	☐	☐	Hepatitis B
☐	☐	Blood Transfusions	☐	☐	Coughing Up Blood	☐	☐	Hepatitis Other
☐	☐	Heart Disease	☐	☐	Hormone Disorder	☐	☐	Jaundice
☐	☐	Artificial Heart Valves	☐	☐	Thyroid Disease	☐	☐	Drug Dependency
☐	☐	Congenital Heart Defects	☐	☐	Adrenal Disease	☐	☐	Eye Disease
☐	☐	Rheumatic Heart Defects	☐	☐	Diabetes	☐	☐	Glaucoma
☐	☐	Rheumatic/Scarlett fever	☐	☐	Kidney Disease	☐	☐	Double Vision/Dizziness
☐	☐	Heart Murmur	☐	☐	Venereal Disease	☐	☐	Epilepsy
☐	☐	High Blood Pressure	☐	☐	Herpes	☐	☐	Ear Disorders
☐	☐	Angina/Heart Attack Pain	☐	☐	AIDS/HIV	☐	☐	Sinus Trouble
☐	☐	Stroke or Blood Clots	☐	☐	Rheumatoid Arthritis	☐	☐	Psychiatric Problems
☐	☐	Pacemaker	☐	☐	Skin Rash/Hives Disorder	☐	☐	Contact Lenses
☐	☐	Cancer	☐	☐	Stomach/Bowel Disorder	☐	☐	Organ transplant
☐	☐	Chemotherapy	☐	☐	Stomach Ulcers	☐	☐	Pins/Plates/Artificial Joints
☐	☐	Radiation Therapy	☐	☐	Colitis	☐	☐	Seizures/Fainting Spells
☐	☐	Malignant Hyperthermia	☐	☐	Loss of Appetite/ Eating Disorder			
☐	☐	Lung Disease	☐	☐	Difficulty Swallowing			
☐	☐	Tuberculosis	☐	☐	Severe Diarrhea			

Do you have any other disease, condition or factro in your medical history which we should know about? Y ☐ N ☐

If yes, please comment: _____

_____

The above medical profile is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

Name _____ Patient ☐

Signature _____ Parent ☐

Date _____ Guardian ☐