TELL US ABOUT YOUR HEALTH

LAST NAME _____ **FIRST NAME** _____

How would you rate your health? Please circle one. Excellent Good Fair Poor

When did you have your last physical exam? _____

If you are under the care of a physician, please give reason(s) for treatment.

_____

Physician's Name, Address, and Telephone Number:

Name _____ Address _____

City _____ State _____ Zip _____ Telephone _____

Have you ever had any kind of surgery? Yes _____ No _____

If yes, what kind? _____ Date _____

_____ Date _____

Have you ever had any trouble with prolonged bleeding after surgery? Yes _____ No _____

Do you wear a pacemaker or any other kind of prosthetic device? Yes _____ No _____

Are you taking any kind of medication or drugs at this time? Yes _____ No _____

If yes, please give name(s) of the medicine(s) and reason(s) for taking them:

Name _____ Reason _____

_____ _____

Have you ever had an unusual reaction to an anesthetic or drug (like penicillin)? Yes _____ No _____

If yes, please explain: _____

Please circle any past or present illness you have had:

Alcoholism	Blood pressure	Epilepsy	Hepatitis	Kidney or liver	Rheumatic fever
Allergies	Cancer	Glaucoma	Herpes	Mental	Sinusitis
Anemia	Diabetes	Head/Neck injuries	Immunodeficiency	Migraine	Ulcers
Asthma	Drug dependency	Heart disease	Infectious diseases	Respiratory	Venereal disease

Are you allergic to Latex or any other substances or materials? Yes _____ No _____

If so, please explain _____

If female, are you pregnant? Yes _____ No _____

Is there any other information that should be known about your health? _____

_____

Signed: Patient or Parent _____ Date: _____