PATIENT MEDICAL HISTORY

Physicians' Name :_____ Last Medical Check-up: ___/___ /___

Are you under a physician's care now? _____ If yes, for what? _____
_____

Are you taking any medications (include and tablets, pills, vitamins, etc.)?_____
If yes, for what? _____

Are you currently taking aspirin on a regular basis?_____

Have you had any major health problems (serious illness, hospitalizations, surgery) in the past 5 years?_____

Do you have or had any of the following problems:

Yes No
___ ___ Headaches
___ ___ Fainting spells, seizures, epilepsy
___ ___ Heart Trouble, Heart Attack
___ ___ Pacemaker
___ ___ Congestive Heart Failure
___ ___ Chest Pain, Shortness of breath , Swollen Ankles
___ ___ High Blood Pressure
___ ___ Low Blood Pressure
___ ___ Blood Disorders, Anemia
___ ___ Blood Test w/unusual results? What test?_____
___ ___ Abnormal Bleeding Why?_____
___ ___ Bruise Easily
___ ___ Tuberculosis, Pneumonia, or other Lung Ailment

Yes No
___ ___ Persistent Cough, Cough Blood
___ ___ Asthma
___ ___ Hay Fever
___ ___ Hepatitis, Jaundice, Liver Disease
___ ___ Diabetes
___ ___ HIV + or AIDS
___ ___ STD Type?_____
___ ___ Kidney Problems
___ ___ Dialysis
___ ___ Prolonged Healing, Sores that did Not heal in 1 week?
___ ___ Arthritis
___ ___ Cancer Diagnosed Where?_____ When? _____
___ ___ Received Radiation, Chemo, or other treatment for tumors

Do you use Tobacco?
Yes No
___ ___ Cigarette____ Pipe____ Other____ How much per day?_____
___ ___ Chemical or Alcohol Dependency

Have you ever had the following:

Yes No

___ ___ Organ Transplant
___ ___ Prosthetic Joint Replacement
___ ___ Rheumatic Heart Disease, Rheumatic Fever
___ ___ Heart Murmur
___ ___ Prolapsed Mitral Valve
___ ___ Antibiotic Pre-Med suggested for any of the above

Are you sensitive or allergic to the following:

Yes No

___ ___ Penicillin
___ ___ Codeine
___ ___ Novocain, Lidocaine or Local Anesthetic
___ ___ Aspirin
___ ___ Anesthetics
___ ___ Latex Products

Any antibiotic, drug or food allergies? (Please list)_____
_____

Do you have any disease or condition not listed above? _____
If yes, please describe:_____

Please add anything you feel is important _____
_____

Women:

Are you pregnant? _____
Are you nursing? _____
Are you currently taking any oral or intramuscular contraceptives? _____
Are you taking hormone replacements? _____

I have advised Dr. Shuster as to whether or not I am currently utilizing birth control pills. I have been advised and informed that certain antibiotics and some pain medications may neutralize the therapeutic effect of birth control pills allowing for conception and resulting in pregnancy. I agree to consult with my family physician to initiate additional forms of mechanical birth control during the period of my treatment and until I am advised that I can return to exclusive birth control pills by my physician.

Initials:_____

Signature:_____Date:___/___/_____