## **MEDICAL HISTORY**

Heart Failure	Circle any of the following which y	ou have had or have at the pres	ent			
Rhematic Fever	☐Heart Failure	□Anemia	□Venereal Disease	□Asthma		
Miral Valve Prolupse	☐ High Blood Pressure	☐Blood in your stool	(Syphilis, Gonorrhea)	☐Any Form of Cancer		
Sworthers of Breath   Stroke   Weight   Dirug or Alcolol Abuse   Persistent Cough   Stroke   Stroke   Weight   Dirug or Alcolol Abuse   Persistent Cough   Searlet Fever   Night Sweats   Dipleys or Seizures   Sinss Trouble   Heart Pacensker   Ulleers   Dirug or Alcolol Abuse   Persistent Cough   Dirug of Alcolol Abuse and Abuse   Dirug of Abuse   Di	☐Rheumatic Fever	☐Blood in Urine	□Nervousness	□Arthritis		
Shortness of Breath	☐Mitral Valve Prolapse	□Diabetes	☐Bruise Easily	☐Food Allergies		
Pensitent Cough	□Swollen Ankles	☐ Heart Disease or Attack	☐Unexplained Gain or Loss of	☐Liver Disease		
Clices   C	☐Shortness of Breath	□Stroke	Weight	☐Drug or Alcohol Abuse		
Radiation Treatment	☐Persistent Cough	☐Scarlet Fever	□Night Sweats	☐Epilepsy or Seizures		
Contisone or Steroid	☐Sinus Trouble	☐ Heart Pacemaker	□Ulcers	☐Psychiatric Treatment		
Medicine	☐Radiation Treatment	☐Chest Pains	☐Kidney Trouble	☐Chronic Diarrhea or		
Characteristics   Chemotherapy   C	☐Cortisone or Steroid	□Emphysema	☐Increase in Thirst	Constipation		
Chemotherapy	□Medicine	☐Tuberculosis (TB)	☐Angina Pectoris	□Recent Fever		
Chemotherapy	□AIDS/HIV	☐Thyroid Disease	_	☐Frequent Infections		
Henothilia	☐Yellow Jaundice	=	☐Artificial Heart Valve			
Grainfing or Dizzy Spells	□Hemophilia	• •	☐Heart Surgery			
Sickle Cell Disease   Blood Transfusion   Chronic Bronchitis	☐Fainting or Dizzy Spells		2 2			
Do You Have Any of the Following Drug Allergies?	☐Sickle Cell Disease	*				
Y   N   Aspirin   Y   N   Codeine   Y   N   Penicillin   Are you taking any medications? What? Please include herbal supplements:   Supple	□Swollen Glands	ablood Tunbiabion	Cinome Bronemus			
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Y   N   Aspirin   Y   N   Codeine   Y   N   Penicillin   Are you taking any medications? What? Please include herbal supplements:   Supple	Do You Have Any of the Following	Drug Allergies?	Are you under a physicians' care? What for?			
Phone (	□ Y □ N Aspirin	☐ Y ☐ N Codeine				
Phone (	☐ Y ☐ N Nitrous Oxide	☐ Y ☐ N Penicillin	N Penicillin Are you taking any medications? What? Please include herbal			
Family Physician  Phone ()    Y   N   Have you ever had a general anesthetic?   Y   N   Have you ever been admitted to a hospital?   Y   N   Have you ever had a bleeding problem following any type of surgery or tooth extractions?   If yes, please explain:       Y   N   Do you smoke? If yes, how much?						
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