PATIENT'S NAME: _____ DATE OF BIRTH: _____

REASON FOR TODAYS VISIT: _____

PATIENT'S MEDICAL HISTORY

1. DATE OF YOUR LAST PHYSICAL EXAM _____
2. PHYSICIAN'S NAME: _____

   PHONE NUMBER: _____
3. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN YES NO
4. DO YOU SMOKE YES NO
5. ARE YOU PREGNANT YES NO
6. ARE YOU ALLERGIC TO OR HAVE HAD REACTIONS TO:

   LOCAL ANESTHETICS LIKE NOVOCAINE YES NO

   PENICILLIN OR OTHER ANTIBIOTICS YES NO

   SULFA DRUGS YES NO

   BARBITURATES, SEDATIVES OR SLEEPING PILLS YES NO

   ASPIRIN YES NO

   IODINE YES NO

   LATEX/RUBBER YES NO

   OTHER: _____
7. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

ANY CARDIAC CONDITIONS:	YES	NO	SHORTNES OF BREATH	YES	NO
IF YES PLEASE LIST _____			HIGH/LOW BLOOD PRESSURE	YES	NO
_____			HEPATITIS	YES	NO
STROKE	YES	NO	SINUS TROUBLE	YES	NO
ASTHMA/ HAYFEVER	YES	NO	DIABETES	YES	NO
AIDS OR HIV INFECTION	YES	NO	TUBERCULOSIS	YES	NO
CHEMOTHERAPY	YES	NO	EPILEPSY OR SEIZURES	YES	NO

8. ARE THERE ANY OTHER MEDICAL CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT:

_____

_____

_____