MEDICAL HEALTH HISTORY (CONTINUED)

Personal History:

Please list your most serious illnesses, injuries and operations:

_____

_____

Please list any known allergies (Other than medications).

_____

_____

Please describe any regular exercise you do.

_____

Are you allergic or have you reacted to:

Local Anesthetics	☐ Yes	☐ No
Penicillin or other Antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Codeine or other Narcotics	☐ Yes	☐ No

Other _____

Have you had abnormal bleeding?	☐ Yes	☐ No
Do you bruise easily?	☐ Yes	☐ No
Have you ever required a blood transfusion?	☐ Yes	☐ No

If so, please explain the circumstances _____

Women:

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No

I certify that I have read and understand the above. I acknowledge that my questions if any about the inquires set forth above have been answered to my satisfaction. I will not hold my physician/dentist, or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Patient Signature Date

_____

Doctor Signature Date