

MEDICAL HEALTH

Name of Physician Phone #

Name of any Specialist Phone #

Have you been under a physician's care during the last 2 years? _____ For? _____

Have you been treated in the hospital in the last 2 years? _____ For? _____

Have you ever had major surgery? _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you had a blood test for hepatitis? _____ Were you vaccinated for hepatitis? _____

Have you had cankers/cold sores on your lips/tongue/body? _____

Are you now or have you taken any prescription drug in the past year? _____ For? _____

Are you allergic to Penicillin Codeine Local Anaesthetics Metal Latex Other? _____

Have you had or do you have:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis of the Liver |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia/Pleurisy | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Easily | <input type="checkbox"/> | <input type="checkbox"/> | Breathing Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> | Coughing Up Blood | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hormone Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valves | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Drug Dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defects | <input type="checkbox"/> | <input type="checkbox"/> | Adrenal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Eye Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Heart Defects | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic/Scarlett fever | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Double Vision/Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Ear Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina/Heart Attack Pain | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke or Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Skin Rash/Hives Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Contact Lenses |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Bowel Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Pins/Plates/Artificial Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> | Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignant Hyperthermia | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite/ Eating Disorder | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Severe Diarrhea | | | |

Do you have any other disease, condition or factro in your medical history which we should know about? Y N

If yes, please comment: _____

The above medical profile is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

Name _____ Patient

Signature _____ Parent

Date _____ Guardian