Medical Questionnaire

Any history of: *Medications for problem*

Heart Problem . . . . Yes No ___________________________________
High Blood Pressure . . . . . . Yes No __________________________________
Rheumatic Fever . . . . Yes No _________________________________
Kidney or Liver Disease . . . . . Yes No _________________________________
Glaucoma . . . . Yes No __________________________________
Allergic to Anesthetic . . . . . . Yes No_________________________________
Emotional Stress . . . . . . Yes No__________________________________
Prolonged Bleeding . . . . . . Yes No _________________________________
Asthma . . . . Yes No____________________________________
Epilepsy / Convulsions . . . . . Yes No___________________________________
Blood Transfusions . . . . . . Yes No___________________________________
Arthritis . . . . Yes No___________________________________
Hepatitis . . . . Yes No___________________________________
Diabetes . . . . Yes No___________________________________
Artificial Joints / Breast Implant . . Yes No___________________________________
Heart Valve Problems / Murmur . . Yes No___________________________________
Tobacco Use . . . . . . .Yes No ___________________________________
Cortisone or ACTH . . . . . Yes No_____________________________________
Anemia . . . . Yes No_____________________________________
Prostate Problem . . . . . Yes No___________________________________
HIV Positive . . . . . . Yes No___________________________________
Lung Disease . . . . . . Yes No___________________________________
Bronchitis . . . . . . Yes No_____________________________________
Contact Lenses . . . . . Yes No_____________________________________
Fever Blisters / Herpes . . . . . Yes No_____________________________________
Cancer . . . . Yes No_____________________________________
Snoring or Sleep Apnea . . . . . Yes No_____________________________________

Your Physicians Name______________________________Phone:______________________
Date of last medical exam_________________ Are you being treated now?___________
Are you taking any medication ? . . . . Yes No
If Yes, what?____
Are you allergic to any medications? . . . . Yes No
If Yes, what?____
Any other allergies or medical problems that aren't listed above? . . . Yes No
If Yes, what? ____

Signature:____Date:__________________