Name: _____ Date: _____

History of Disease

Lungs

Yes No

- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Chronic or A.M. Cough

Vascular

- ☐ ☐ High Blood Pressure
- ☐ ☐ Chest Pain / MI / TIA
- ☐ ☐ Heart Murmur / Valve Disease
- ☐ ☐ Palpitation / Irregular or Fast Heart Beat
- ☐ ☐ Pacemaker

Systemic

Yes No

- ☐ ☐ Diabetes
- ☐ ☐ Thyroid Trouble
- ☐ ☐ Kidney / Bladder Problems
- ☐ ☐ Stomach / Bowel Problems
- ☐ ☐ Hepatitis / Yellow Jaundice
- ☐ ☐ Convulsions / Epilepsy / Seizures
- ☐ ☐ Fainting
- ☐ ☐ Glaucoma
- ☐ ☐ Alcohol
- ☐ ☐ AIDS / HIV or Exposure
- ☐ ☐ Phlebitis (History)
- ☐ ☐ Joint Deformity

Skin

- ☐ ☐ Hives
- ☐ ☐ Hay Fever
- ☐ ☐ Skin Cancer, if yes, explain. _____

_____

- ☐ ☐ Do You Smoke? If yes, how much? _____
- ☐ ☐ (Women) Are you pregnant? If yes, expected date? _____
- ☐ ☐ Do you bleed easily?
- ☐ ☐ Do you have any allergies? If yes, list. _____

_____

- ☐ ☐ Do you have any other disease, condition or problems that we should know about? If yes, list. _____

_____

- ☐ ☐ Have you ever had a blood transfusion? If yes, when? _____
- ☐ ☐ Have you ever had any reaction to a local anesthetic? If yes, explain. _____

_____

- ☐ ☐ Have you been instructed to take any prophylactic antibiotics prior to surgical procedure? If yes, why? _____

Drug History

_____ Steroids	_____ Arthritic Medications	_____ Diabetic Medication
_____ Birth Control Pills	_____ Tranquilizers	_____ Thyroid Medication
_____ Anti-Coagulants	_____ Narcotics	_____ Blood Pressure Medication
_____ Heart Medication	_____ IV or Recreational Drugs	_____ Aspirin / Blood Thinners (Persantine, Coumadin, etc...)

Current Medications: _____

_____

_____

Recent Operations (past 10 years): _____

_____

Describe your skin problem: _____