Medical History

Name____ Age_______

Do you have now or have you ever had problems with or treatment for any of the following? (**Please circle Yes or No**):

Heart Trouble or Disease	Yes	No		Tuberculosis	Yes	No
Heart Valve Abnormalities	Yes	No		Anemia	Yes	No
Mitral Valve Prolapse	Yes	No		Blood Disorder or Disease	Yes	No
Heart Murmur	Yes	No		Bleeding Disorder or Tendency	Yes	No
Chest Pain or Angina	Yes	No		Liver Disease	Yes	No
Heart Attack	Yes	No		Hepatitis or Jaundice	Yes	No
Irregular Heart Beat	Yes	No		Alcohol Use	Yes	No
Heart Pacemaker	Yes	No		Immune System Disorder	Yes	No
Heart Surgery	Yes	No		AIDS or HIV +	Yes	No
Heart Deformities	Yes	No		Diabetes	Yes	No
Rheumatic Fever	Yes	No		Kidney Trouble	Yes	No
High or low blood pressure	Yes	No		Seizures, Convulsions or Epilepsy	Yes	No
Stroke or Mini Stroke	Yes	No		Ulcers or Acid Reflux	Yes	No
Shortness of Breath	Yes	No		TMJ (Jaw Joint) Problems	Yes	No
Breathing Problems	Yes	No		Jaw Joint Clicking/Popping or Pain	Yes	No
Asthma	Yes	No		Mental Health Problems	Yes	No
Emphysema	Yes	No		Glaucoma	Yes	No
Bronchitis or Chronic Cough	Yes	No		Chemotherapy	Yes	No
Lung Disease or Problems	Yes	No		Radiation Treatment	Yes	No
Sleep Apnea	Yes	No		Recreational Drug Use	Yes	No

Please Circle Yes or No to the Following Questions:

Are you allergic to any medications, eggs or latex? **Yes No** (**Please List**) ____

____

Do you take any medications? **Yes No** (**Please List on Back of Sheet**)

Have you been in the hospital in the last 5 years? **Yes No** (**Please List Reasons**) ______________________________________

Are you now or have you been under the care of a physician during the past 5 years? **Yes No**

If yes, for what? ____

Have you ever had any type of surgery? **Yes No** (**Please list**): ____

____

Have you or anyone in your family ever had any problems with general anesthesia? **Yes No**

If yes, please explain: ____

Do you use **Aspirin, BC** or **Goody Powder**? **Yes No** (**If yes, how often?**)____

Have you ever had any excessive bleeding requiring special treatment? **Yes No**

(**If yes, please explain:**) ____

Do you have any artificial joints or heart valves? **Yes No** (**If yes, please list:**) ____

(Continued on Reverse Side)

Have you been on any steroid medication in the past year? **Yes No** (**If yes, how long** were you on the steroid medication?)_____

Do you use any tobacco? **Yes No** (**If yes, please circle the type** you use:) Cigarettes, Cigars, Pipe, Smokeless.
How long used? ________________________ Approximate amount used per day? ________________________

Women, are you pregnant or breast feeding? **Yes No**

Do you have difficulty breathing through your nose? **Yes No**; Would you like information on treatment that is available? **Yes No**

Do you snore? **Yes No**; Would you like information on treatment that is available? **Yes No**

List any other medical problems or conditions you have: ____

Are you happy with the appearance of your ears? **Yes No**

Are you happy with the appearance of your eyelids? **Yes No**

Are you happy with the appearance of your nose? **Yes No**

Are you happy with the appearance of your chin? **Yes No**

Are you happy with the appearance of your face and facial skin? **Yes No**

If you answered no to any of the above cosmetic questions, would you like information on treatment that is available? **Yes No**

List All Your Medications	Dose	Frequency

Do you take more medications than listed above? **Yes No**
If yes, **Continue your medication list on additional "Medication List" provided.**

The above questions have been answered truthfully and reflect my current state of health,

Patient's (or authorized guardian) Signature: ____ Date: _________

Doctor Signature: ____ Date:__________

Medication List

List All Your Medications	Dose	Frequency

The above questions have been answered truthfully and reflect my current state of health,

Patient's Signature: ____ **Date:** ___________________

Doctor Signature: ____ Date:____________________