

Medical History

Name of Medical Doctor: City/State:	Last Name:	First Name:	Birthdate:
Emergency Contact Phone Relationship If under 18 please list approximate height and weight:	Name of Medical Doctor:		
If under 18 please list approximate height and weight: List all medications that you are now taking: Are you allergic to any of the following? Mark all that apply: Ansy there allergies? Do you currently have or have you had any of the following medical conditions? Mark all that apply: Breathing disorder Kidney Disease Bleeding Problems Liver Disease Cancer Pregnancy Diabetes Neurological Treatment Heart Trouble Stroke High Blood Pressure Gastrointestinal Issues or Ulcers Joint Replacement Infectious Disease (Herpes, AIDS, etc.) Any additional medical information, disease, condition, or problem not listed above? Unusual reaction to dental injections? Female Patient: Are you pregnant or nursing? Female Patient: Do you take birth control? Have you ever take	Emergency Contact	Phone	
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Codeine Penicillin Ibuprofen Sulfa Any other allergies?	Anesthetic		□ Iodine
Ibuprofen Sulfa Any other allergies?	Aspirin		□ Latex
Any other allergies?			Penicillin
Do you currently have or have you had any of the following medical conditions? Mark all that apply: Breathing disorder Kidney Disease Bleeding Problems Liver Disease Cancer Pregnancy Diabetes Neurological Treatment Heart Murmur Sinus Trouble Heart Trouble Stroke Joint Replacement Rheumatic Fever Thyroid Condition Infectious Disease (Herpes, AIDS, etc.) Any additional medical information, disease, condition, or problem not listed above? Female Patient: Are you pregnant or nursing? Female Patient: Do you take birth control?	Ibuprofen		Sulfa
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	marijuana? If so, what kind and	how much?	
	Have you ever used the above past? If yes, when did you quit?		