

## Medical History

### Past medical history: (Circle all that apply)

Coronary artery disease or heart problems      Respiratory problems

High blood pressure    Diabetes    Elevated cholesterol    Hx of hepatitis

Do you suffer from migraines or migraines with aura?    Yes    No

List other major medical problems: \_\_\_\_\_

\_\_\_\_\_

List major surgeries: \_\_\_\_\_

\_\_\_\_\_

Have you ever had an allergic reaction to "Novocaine" or other local anesthetics?    Yes    No

Do you have a latex allergy?    Yes    No

List allergies to other medications: \_\_\_\_\_

Do you take aspirin, motrin, coumadin or other blood thinners

Please list current medications \_\_\_\_\_

\_\_\_\_\_

Are you a cigarette smoker?    Yes    No    If yes, pack(s) per day \_\_\_\_

Average alcohol consumption:    Never    Occasional    Moderate    Heavy

**Patient signature** \_\_\_\_\_