			DATE:			
Medical History Continue	ed		NAME:			
	YES	NO			YES	NO
Are you allergic to or have you had reactions to:			8.	Low blood pressure?	0	
 Local anesthetics like novocaine? 				Hepatitis, jaundice or liver disease	? 🗖	
Penicillin or other antibiotics?				Stroke?		
Sulfa drugs?			11.	Sinus trouble?		
4. Barbiturates, sedatives or sleeping pills?			12.	Lung or breathing problems?		
5. Aspirin?			13.	Asthma or hay fever?		
6. lodine?			14.	Hives or skin rash?		
7. Other?			15.	Fainting spells or seizures?		
			16.	Diabetes?		
 Rheumatic heart disease or rheumatic fever? 			17.	AIDS or HIV infection?		
Scarlet fever?			18.	Thyroid problems?		
Heart defect or heart murmur?				Allergies?	o	
Heart trouble, heart attack, or angina?				Arthritis or rheumatism?	ō	ō
 a. Do you have pain in your chest 				Joint replacement or implant?	ō	ō
upon exertion?				Stomach ulcer?	ō	ō
 b. Are you ever short of breath after 				Kidney trouble?	ō	ō
mild exercise?				Tuberculosis?	ī	ŏ
c. Do your ankles swell?				Persistent cough?	ī	ŏ
d. Do you get short of breath			26.	<u>~</u>	ă	ŏ
when you lie down?				Cancer?	ă	ŏ
 e. Do you require extra pillows when 				Sexually transmitted disease?	ä	ŏ
you sleep?					-	
Pacemaker?			29.			
6. Heart surgery?				Anemia?		
7. High blood pressure?				Leukemia? Glaucoma?		
SIGNATURE OF PATIENT, PARENT, or GUARDIAN				DATE		
URRENT MEDICATIONS:						
NY HEALTH CHANGES NOT LISTED ABOVE:		-				
JPDATES						
PATE COMMENT					INITIALS	
		·				