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PATIENT HISTORY QUESTIONNAIRE

Are you currently under the care of or have you ever been treated by a Medical Physician for any significant reason other than flu or virus

Have you had any Surgical Procedures in the past?

<u>Date</u>	<u>Type of Surgery</u>	<u>Name of Doctor/Hospital</u>

Do you have any bleeding tendencies? Yes _____ No _____
Do you have any allergies to medications? Yes _____ No _____

PENICILLIN YES _____ NO _____
LOCAL ANESTHETIC YES _____ NO _____
ANY OTHERS YES _____ NO _____

IF YES PLEASE SPECIFY: _____

Are you presently taking any medications? _____

ASPIRIN YES _____ NO _____
ORAL CONTRACEPTIVES YES _____ NO _____
BLOOD THINNERS YES _____ NO _____
ANY OTHERS YES _____ NO _____
HEIGHT _____
WEIGHT _____

IF YES PLEASE SPECIFY:
MEDICATION: _____
DOSAGE: _____
FREQUENCY: _____

DO YOU DRINK ALCOHOL YES _____ NO _____ IF SO HOW MUCH? _____
DO YOU SMOKE CIGARETTES YES _____ NO _____
IF YES HOW MANY PACKS A DAY _____

IF YOU HAVE ANY HISTORY OF USE OF CONTROLLED SUBSTANCES
PLEASE BRING IT TO YOUR DOCTOR'S ATTENTION