

# Medical Information

Please place a check mark next to any medical condition you have had or currently have:

- |                                              |                                                  |                                          |
|----------------------------------------------|--------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Pacemaker     | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Diabetes        |
| <input type="checkbox"/> Bleeding Problems   | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Jaundice        |
| <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> HIV                 | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Hemophilia      |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Recent Weight Loss  | <input type="checkbox"/> Convulsions/Epilepsy    | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> Glaucoma        |
| <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Pregnant        |
| <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Sinus Trouble   |

Please list all medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic or sensitive to:

- |                                     |                                  |                                  |                                           |
|-------------------------------------|----------------------------------|----------------------------------|-------------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Demerol | <input type="checkbox"/> Valium  | <input type="checkbox"/> Halcion          |
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Latex   | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic |

Other: \_\_\_\_\_