



Patient Medical History

Please Print

Indicate if you are allergic to any of the following medications:

Penicillin _____ Sulfa _____ Codeine _____ Other _____

Indicate if you have any of the following conditions:

Diabetes _____ High Blood Pressure _____ Heart Disease _____

Cancer _____ Arthritis _____ TB _____

AIDS/HIV _____ Hepatitis _____

List all medications you are currently taking, including birth control pills and medications you can buy without a prescription. Please give the dose you take of each medication.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Past Medical History (include any operations in the past 5 years):

Signature _____

Date _____