

Medical Information

Patient Name _____

Emergency Contact: _____ Phone #: _____

Personal Medical Doctor: _____ City: _____

Are You Receiving Medical Attention Now? (Yes) (No)

For What Condition? _____

Are You Taking Medication? (Yes) (No) For What Condition? _____

List All Medications and Reasons For Use: _____

Have you Had or Do You Currently Have Any of The Following Conditions? Circle All That Apply

- | | | |
|-------------------|---------------------|---------------------------------------|
| Diabetes | Heart Condition | Rheumatic Fever |
| Epilepsy | High Blood Pressure | Heart Murmur or Valve Prolapse |
| Hepatitis | Pacemaker | Artificial Valve |
| Asthma | Heart Attack | Artificial Joint |
| Blood Transfusion | Prolonged Bleeding | Need to Pre-Medicate with Antibiotics |
| Anemia | Stroke | AIDS |
| Depression | Social Disease | Women: Are you Pregnant or Nursing |

Are you Allergic to: Latex Codeine Antibiotics Dental Anesthetic Other Drugs(list below)

Other Allergies: _____

Type of Allergic Reaction and How Long Ago: _____

Do You Snore? (Y) (N) If yes, Do You Gasp or Hold Your Breath? (Y) (N)

Does Anyone in Your Household Snore? (Y) (N) Who? _____

Do They Gasp or Hold Their Breath? (Y) (N)

Signature _____ Date _____