

DATE _____

PATIENT'S
NAME _____

DATE OF BIRTH _____ AGE _____

DATE OF LAST MEDICAL EXAMINATION _____

DO YOU HAVE OR HAVE
YOU EVER HAD: YES NO

ANEMIA _____

DIABETES _____

HEPATITIS _____

ALLERGIES _____

TO PENICILLIN _____

TO LOCAL ANESTHETIC _____

ABNORMAL HEART CONDITION _____

ABNORMAL BLEEDING FROM A CUT _____

RHEUMATIC FEVER _____

HEART MURMUR .. _____

ARE YOU TAKING ANY MEDICATION? ... _____

IF SO, WHAT? _____

OTHER PHYSICAL CONDITIONS _____

ARE YOU UNDER THE CARE OF A
PHYSICIAN NOW? _____

NAME OF PHYSICIAN _____

TELEPHONE NUMBER _____

SIGNATURE _____