MEDICAL HISTORY (cont.)

	DATE / /	DATE / /
9. Do you have or have you ever had any of the following?		
A. Rheumatic fever or Rheumatic heart disease?	Yes ❒ No ❒	Yes ❒ No ❒
B. Congenital heart disease?	Yes ❒ No ❒	Yes ❒ No ❒
C. Heart Murmur?	Yes ❒ No ❒	Yes ❒ No ❒
D. Allergy?	Yes ❒ No ❒	Yes ❒ No ❒
E. Asthma or hay fever?	Yes ❒ No ❒	Yes ❒ No ❒
F. Sinus trouble?	Yes ❒ No ❒	Yes ❒ No ❒
G. Hives or skin rash?	Yes ❒ No ❒	Yes ❒ No ❒
H. Fainting spells or seizures?	Yes ❒ No ❒	Yes ❒ No ❒
I. Epilepsy?	Yes ❒ No ❒	Yes ❒ No ❒
J. Hepatitis, Jaundice, or liver disease?	Yes ❒ No ❒	Yes ❒ No ❒
K. Arthritis?	Yes ❒ No ❒	Yes ❒ No ❒
L. AIDS?	Yes ❒ No ❒	Yes ❒ No ❒
M. Inflammatory rheumatism?	Yes ❒ No ❒	Yes ❒ No ❒
N. Stomach Ulcers?	Yes ❒ No ❒	Yes ❒ No ❒
O. Cardiovascular disease?		
(Heart trouble, heart attack, stroke, coronary insufficiency, coronary damaged heart valves, heart murmur, artificial heart valve)	Yes ❒ No ❒	Yes ❒ No ❒
1. Do you have chest pain upon exertion?	Yes ❒ No ❒	Yes ❒ No ❒
2. Are you ever short of breath after mild exercise?	Yes ❒ No ❒	Yes ❒ No ❒
3. Do your ankles swell?	Yes ❒ No ❒	Yes ❒ No ❒
4. Do you get short of breath when you lie down, or do you require an extra pillow when you sleep?	Yes ❒ No ❒	Yes ❒ No ❒
5. Do you have a cardiac pacemaker?	Yes ❒ No ❒	Yes ❒ No ❒
P. Kidney Trouble?	Yes ❒ No ❒	Yes ❒ No ❒
Q. Do you have a persistent cough or cold?	Yes ❒ No ❒	Yes ❒ No ❒
R. Diabetes?		
1. Do you have to urinate (pass water) more than six times a day?	Yes ❒ No ❒	Yes ❒ No ❒
2. Are you thirsty much of the time?	Yes ❒ No ❒	Yes ❒ No ❒
3. Does your mouth frequently feel dry?	Yes ❒ No ❒	Yes ❒ No ❒
S. Low Blood Pressure?	Yes ❒ No ❒	Yes ❒ No ❒
T. Tuberculosis?	Yes ❒ No ❒	Yes ❒ No ❒
U. Venereal Disease? (syphilis, Gonorrhea, etc.)	Yes ❒ No ❒	Yes ❒ No ❒
V. Sickle Cell Disease?	Yes ❒ No ❒	Yes ❒ No ❒
W. Cancer or chemotherapy, or radiation treatment, Leukemia?	Yes ❒ No ❒	Yes ❒ No ❒
X. Glaucoma (open, closed angle)	Yes ❒ No ❒	Yes ❒ No ❒
Y. Other? _____		
10. Have you had abnormal bleeding associated with any previous surgery, extraction or trauma?	Yes ❒ No ❒	Yes ❒ No ❒
11. Do you have any blood disorder(s)? (anemia?)	Yes ❒ No ❒	Yes ❒ No ❒
A. Any family history of bleeding disorders?	Yes ❒ No ❒	Yes ❒ No ❒
12. Are you taking any of the following? If yes, please list name	Yes ❒ No ❒	Yes ❒ No ❒
A. Antibiotics or sulfa drugs? _____		
B. Anticoagulants? _____		
C. Medicine for high blood pressure? _____		
D. Tranquilizers? _____		
E. Cortisone, steroids? _____		
F. Aspirin? _____		
G. Antihistamines? _____		
H. Insulin, tolbutamide, orinase, or similar _____		
I. Digitalis or drugs for the heart? _____		
J. Nitroglycerin? _____		
K. Other? _____		