

<b>MEDICAL ALERT</b>	<u>CONDITION</u>	<u>PRESCRIPTION</u>	<u>ALLERGIES</u>	<u>ANAEST.</u>
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**ALLERGIES** Please check off any medications you are allergic to or you have reacted adversely to:

<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Nembutal	<input type="checkbox"/> Demerol	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Rovamycin	<input type="checkbox"/> Local Anaesthetic (Freezing)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Seconal	<input type="checkbox"/> Percodan	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Cedhalexin	<input type="checkbox"/> Nitrous Oxide
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Darvon	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Sulpha Drugs	<input type="checkbox"/> Amoxicillin
<input type="checkbox"/> Tylenol #2, #3, #4	<input type="checkbox"/> Toradol	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Scopolamine	<input type="checkbox"/> Metal	<input type="checkbox"/> Chlorhexidene (Peridex)
<input type="checkbox"/> 222, 282, 292	<input type="checkbox"/> Codeine	<input type="checkbox"/> Valium	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex	<input type="checkbox"/> Bandage

Food Allergies, please list:

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Please list any other medications or substances which you know you are allergic to:

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\_\_\_\_\_

**MEDICAL CONDITIONS** Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)

	No			NS			Yes		
	No	NS	Yes	No	NS	Yes	No	NS	Yes
Malignant Hyperthermia									
Stomach/Intestinal Problems									
Transdermal Nicotine Patches									
High Blood Pressure/Hypertension									
Low Blood Pressure									
Heart Failure									
Congenital Heart Lesion									
Artificial Heart Valve									
Heart Pacemaker									
Heart Surgery									
Heart Murmur									
Mitral Valve Prolapse									
Chest Pain									
Angina Pectoris									
Shortness of Breath									
Stroke									
Fainting or Dizziness									
Anemia									
Cardiac Arrest/ Heart Attack									
Swelling of Feet/Ankles/Hands									
Drug or Alcohol Addiction									
Scarlet Fever									
Kidney Trouble									
Ulcers									
Asthma									
Hay Fever									
Sinus Trouble									
Emphysema									
Frequent Cough									
Lung Disease									
Bronchitis									
Tuberculosis									
Liver Disease									
Hepatitis A (infect.)									
Hepatitis B (serum)									
Hepatitis C									
Yellow Jaundice									
Thyroid Disease									
Glaucoma									
Pain in Jaw Joints									
Head/Neck Injuries									
Rheumatic Fever									
Artificial Joints/Hips									
Diabetes or Hypoglycemia									
Arthritis/Rheumatism									
Epilepsy or Seizures									
Glandular Disorders									
Psychiatric Care									
Mental/Nervous Disorders									
AIDS(HIV Positive)									
Venereal Disease									
Herpes									
Cold Sores									
Fever Blisters									
Blood Disorders									
Circulation Problems									
Sickle Cell Anemia									
Hemophilia									
Cancer									
Chemotherapy/Radiation									
X-Ray/Cobalt Treatment									

If Yes, have you received treatment? \_\_\_\_\_ Where? \_\_\_\_\_

Is there anything we have not mentioned that you think we should know regarding your medical history?

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<b>WOMEN ONLY</b>	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking Birth Control Pills? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Are you nursing? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking Fertility drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>

Follow-up information to above questions:

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