

Name: _____

Do you have or have had any of the following:

- | Circle YES or NO | | | Circle YES or NO | | |
|---------------------------|-----|----|-------------------------|-----|----|
| 1. Artificial Heart Valve | YES | NO | 20. Heart Problems | YES | NO |
| 2. Aid/HIV+ | YES | NO | 21. High Blood Pressure | YES | NO |
| 3. Anemia | YES | NO | 22. Jaundice | YES | NO |
| 4. Angina | YES | NO | 23. Joint Replacement | YES | NO |
| 5. Arthritis | YES | NO | 24. Kidney Disease | YES | NO |
| 6. Asthma | YES | NO | 25. Latex Allergy | YES | NO |
| 7. Bleeding Problems | YES | NO | 26. Liver Problems | YES | NO |
| 8. Cancer | YES | NO | 27. Low Blood Pressure | YES | NO |
| 9. Chemo/Rad Therapy | YES | NO | 28. Lung Disease | YES | NO |
| 10. Diabetes | YES | NO | 29. Pacemaker | YES | NO |
| 11. Dizzy Spells | YES | NO | 30. Psychiatric Care | YES | NO |
| 12. Drug Addiction | YES | NO | 31. Rheumatic Fever | YES | NO |
| 13. Emphysema | YES | NO | 32. Sinus Trouble | YES | NO |
| 14. Epilepsy | YES | NO | 33. Smoking Tobacco | YES | NO |
| 15. Fainting | YES | NO | 34. Stroke | YES | NO |
| 16. Glaucoma | YES | NO | 35. Thyroid Problems | YES | NO |
| 17. Heart Attack | YES | NO | 36. TMD or TMJ | YES | NO |
| 18. Heart Surgery | YES | NO | 37. Tuberculosis | YES | NO |
| 19. Heart Murmur | YES | NO | 38. Venereal Disease | YES | NO |

Patient Signature _____ **Date** _____

1. Patient Signature _____ Date _____

2. Patient Signature _____ Date _____

3. Patient Signature _____ Date _____

Doctors Signature _____ **Date** _____