PAST MEDICAL HISTORY

DIABETES	Yes _____ No _____	KIDNEY DISEASE	Yes _____ No _____
EMPHYSEMA	Yes _____ No _____	LIVER DISEASE	Yes _____ No _____
FACIAL TRAUMA	Yes _____ No _____	LUNG DISEASE	Yes _____ No _____
GLAUCOMA	Yes _____ No _____	PREGNANT	Yes _____ No _____
HEART DISEASE	Yes _____ No _____	THYROID DISEASE	Yes _____ No _____
HYPERTENSION	Yes _____ No _____		

CHEST X-RAY DATE _____ RESULT _____
SINUS X-RAY DATE _____ RESULT _____

Do you smoke? Yes _____ No _____
Packs per day _____ How many years _____

Tonsilectomy and/or adenoidectomy Yes _____ No _____
Frequent infections Yes _____ No _____ Number per year ___ TYPE _____

MEDICATION HISTORY

Have you ever had adverse symptoms from aspirin? Yes _____ No _____
If so, describe symptoms _____
List all other medications used for allergy or other conditions including those taken orally, injected or ointments for the skin

Medications presently and or previously	**Date and How Often used**	**Helped**	**No help**	**Describe any reactions ill –effects**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever had drug allergies or reactions? Yes _____ No _____
Describe

Drug	**Date Taken**	**Reactions**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____