PAST MEDICAL HISTORY

DIABETES Yes _____ No ______
EMPHYSEMA Yes _____ No ______
FACIAL TRAUMA Yes _____ No ______
GLAUCOMA Yes _____ No ______
HEART DISEASE Yes _____ No ______
HYPERTENSION Yes _____ No ______

KIDNEY DISEASE Yes _____ No ______
LIVER DISEASE Yes _____ No ______
LUNG DISEASE Yes _____ No ______
PREGNANT Yes _____ No ______
THYROID DISEASE 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**
______________________	________________________	___________________________________
______________________	________________________	___________________________________
______________________	________________________	___________________________________