

**Please Complete This Medical History**

	Yes	No
Are you in good health?	_____	_____
Are you now or have you been under the care of a physician during the last 2 years?	_____	_____
Do you have diabetes?	_____	_____
How long have you had diabetes _____		
Medication and dosage _____		
What does your blood sugar generally run _____		
Can you tolerate aspirin products?	_____	_____
Do you have any history of bleeding ulcers or hiatal hernia?	_____	_____
Have you ever experienced ill effects from any type of anesthesia?	_____	_____
Have you ever been treated for heart trouble, asthma, epilepsy anemia, rheumatic fever, tuberculosis, kidney or liver involvement? (please circle those which apply)		
Are you subject to any nervous disorders, fainting or dizziness?	_____	_____
Are you subject to prolonged bleeding?	_____	_____
Is there any family history of diabetes, gout, heart trouble, varicose veins, neuromuscular disease or peripheral vascular disease? (please circle those which apply)		

PRESENT MEDICATIONS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DRUGS OTHER THAN PRESCRIBED \_\_\_\_\_

DRUG ALLERGIES \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

ILLNESSES \_\_\_\_\_  
\_\_\_\_\_

OPERATIONS \_\_\_\_\_  
\_\_\_\_\_

INJURIES \_\_\_\_\_

ALCOHOL USE Yes \_\_\_\_\_ No \_\_\_\_\_ Amount \_\_\_\_\_

TOBACCO USE Yes \_\_\_\_\_ No \_\_\_\_\_ Amount \_\_\_\_\_