ALLERGIC REACTIONS TO MEDICATIONS _____ YES _____NO **IF *YES*, give medication and type of reaction**

_____

ALLERGIC REACTIONS TO OTHER MATERIALS? _____ YES _____NO, **If *YES*, give material name and type of reaction**

(i.e. latex, iodine, food, etc.) _____

PRESCRIPTION MEDICATIONS

MEDICATION	STRENGTH	TIMES	LAST DOSE	MEDICATION	STRENGTH	TIMES	LAST DOSE

NON-PRESCRIPTION MEDICATIONS (I.E. HERBS, VITAMINS)

MEDICATION	STRENGTH	TIMES	LAST DOSE	MEDICATION	STRENGTH	TIMES	LAST DOSE

DO YOU HAVE ANY OF THE FOLLOWING?
(please circle appropriate answer)

YES **NO**

_____ _____ EYEGLASSES/CONTACTS

_____ _____ DENTURES/BRIDGE

_____ _____ HEARING AIDS

_____ _____ ASPIRIN WITHIN THE LAST WEEK

_____
PATIENT/AUTHORIZED SIGNATURE

___PATIENT ___POWER OF ATTORNEY ___LEGAL GUARDIAN

ANY ADDITIONAL INFORMATION/**FAMILY HISTORY** THAT WILL BENEFIT YOUR PROCEDURE

_____

_____

_____

_____

******NO ASPIRIN/IBUPROFEN/ARTHRITIS PRODUCTS OR PRODUCTS CONTAINING THESE FOR ONE WEEK PRIOR TO THE PROCEDURE WITHOUT PHYSICIAN APPROVAL.***

Any other medical problems not listed above? _____

_____

Any surgical operations? _____

_____

Has the patient had any problems with anesthesia or sedation? _____ YES _____NO, EXPLAIN _____

_____

Has the patient ever been hospitalized for any reason other than surgery? _____ YES _____NO, EXPLAIN _____

_____