

Patient medical history

1. Allergies

2. Risk factors

(Are you currently using any of these medications)

Cortisone	
Anti-Inflammatories	
Anti-Depressants	
Sedatives	
Anti-Coagulants	
Aspirin	
Antibiotics	

3. Medication history

(Home medication eg. High blood pressure medication)

4. Medical history

(E.g. High blood pressure, diabetes)

Do you smoke?

Y/N

If yes, how many per day?

Patient signature

Date