

MEDICAL HISTORY

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Are you on a special diet? Do you use tobacco? Do you use controlled substances? Do you need to pre-medicate?				No No No No No No	If yes, please explain: _ If yes, please explain: _ If yes, please explain: _					- - -	
Women: Are you Preg Are you allergic to any			• . •		No	Taking oral contracep	otives?	Yes	No Nursing?	Yes	No
Aspirin Pe	enicillin		Codeine A	crylic		Metal Latex		Local	Anesthetics		
Other If yes, pleas	se expla	iin:									
Do you have or have y	ou bod	any of	f the following?								
Do you have, or have y IDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Izheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
naphylaxis	Yes	No	Substance Abuse	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
nemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
ngina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
rthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
rtificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
rtificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
sthma	Yes	No	Fainting Spells/Dizzines	s Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	e Yes	No
lood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
lood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
reathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
ruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
ancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
hemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
thest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
old Sores/Fever Blisters	Yes	No	Heart Murmur	Yes		Psychiatric Care	Yes	No	Venereal Disease	Yes	No
ongenital Heart Disorder convulsions	Yes Yes	No No	Heart Pace Maker Heart Trouble/Disease	Yes Yes	No No	Radiation Treatments Recent Weight Loss	Yes Yes	No No	Yellow Jaundice	Yes	No
Javo vou over had any	serious	illness	s not listed above?	Yes	No	If yes, please explain	:				