

MEDICAL HISTORY

Current Physician _____

Yes No Are you under any medical treatment now? What for? _____

Yes No Have you had any major operations? What and when? _____

Yes No Have you ever had a serious accident involving head or jaw injuries?

Yes No Are you allergic or have you reacted adversely to any medications such as aspirin, codeine, penicillin, anesthesia, other _____

Yes No Have you ever had any of the following:

| | |
|--|--|
| <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Any Blood Disease |
| <input type="checkbox"/> By Pass | <input type="checkbox"/> Any Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Any Liver Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Any Stomach or Intestinal Disease |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Any Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Rheumatism or Arthritis | <input type="checkbox"/> AIDS |

Yes No Are you now taking drugs or medications? Please list in next column.

Yes No Are you allergic to any known materials resulting in hives, asthma, eczema, etc? What? _____

Yes No Do you have any reason to suspect you are not in good health?

Yes No Do you have any wounds that healed slowly or presented other complications?

Yes No Are you pregnant?

Yes No Do you have a history of fainting?

Yes No Have you ever had any Chemotherapy or Radiation Therapy?

Yes No Have you received any donor organs, artificial heart valves, vessels, joint implants or pacemaker?

MEDICATIONS & DOSAGE

UPDATED

| | | |
|--|--|--|
| | | |
| | | |
| | | |