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:

___Heart Ailment
___Mitral Valve Prolapse
___Murmur
___Heart Attack
___By Pass
___Stroke
___High Blood Pressure
___Respiratory Disease
___Diabetes
___Rheumatic Fever
___Rheumatism or Arthritis
___Tumors or Growths
___Hepatitis
___Cancer
___Any Blood Disease
___Any Kidney Disease
___Any Liver Disease
___Any Stomach or Intestinal Disease
___Any Venereal Disease
___Epilepsy
___Tuberculosis
___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 <u>not</u> 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

_____ _____ _____
_____ _____ _____
_____ _____ _____