NAME_____DATE OF BIRTH_____/_____/_____DATE_____

PATIENT MEDICAL HISTORY

YES NO Are you under any Medical treatment now?
YES NO Have you had any major operations? If so, what?_____
YES NO Have you ever had a serious accident involving head or jaw injuries?
YES NO Have you had any adverse response to any drugs including penicillin and aspirin?
YES NO Have you ever had any of the following?

- ☐ Any Blood Disease
- ☐ Any Liver Disease
- ☐ Any Kidney Disease
- ☐ Any Stomach or Intestinal Disease
- ☐ Any Venereal Disease
- ☐ Yellow Jaundice or Hepatitis
- ☐ Epilepsy
- ☐ AIDS
- ☐ Heart Ailment
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Rheumatism or Arthritis
- ☐ Tumors or Growths

YES NO Are you on a diet at this time?
YES NO Are you now taking drugs or medications?
Yes NO Are you now or have you ever used any tobacco products?
YES NO Are you allergic to any known materials resulting in – hives, asthma, ecxema, etc?
YES NO Do you have any reason to suspect that you are <u>not</u> in good health?
YES NO Are you pregnant?
YES NO Do you have a history of fainting?
YES NO Have you ever had any X-RAY TREATMENTS (other than diagnostic)?
YES NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?
YES NO Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
YES NO Have you ever take Fen-Phen/Redux?
YES NO Do you have a history of Tuberculosis?

Signature_____

Date	Changes	Signature

PATIENT'S NAME

_____