MEDICAL HISTORY

Are you under a physician's care now?	37/	100		50	ody. Health problems that you ma eceive. Thank you for answering th
Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fen or Redux? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Asplrin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: O you have, or have you had, any of the following? Albehimer's Disease Cold Sores/Fever Bilsters Genital Herpes Kidney Problems Shingles Anaphylaxis Congenital Heart Disorder Giaucoma Leukemia Sickle Cell Disease Anaphylaxis Condicine Heart Attack/Failure Low Blood Pressure Spina Bilida Andritical Heart Valve Diabetes Heart Murmur- Lung Disease Stroke Artificial Heart Valve Drug Addiction Heart Attack/Failure Lung Disease Thyroid Disease Blood Transfusion Excessive Bleeding Heaphilia Parathyroid Disease Thyroid Disease Blood Transfusion Excessive Bleeding Heaphilis Bor C Radiation Treatments Toberculosis Brusse Easily Prequent Cough Hives or Rash Reumatism Vellow Jaundice ave you ever had any serious illness not listed above? Yes No If yes, please explain:	Are yo	u under a physician's care now	Yes O No If yes, p	elease explain:	
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he best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can t	-				

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