MEDICAL HISTORY

PLEASE FILL THIS SECTION OUT CAREFULLY AND COMPLETELY. We are concerned with the whole body and we must be informed of any and all pertinent medical information to ensure his/her well being.

Please Circle The Right Answer:

Are you under a doctor's care? Y or N
Do you suffer or have you suffered from:

HEART AILMENTS	*YES OR NO*	*EPILEPSY*	*YES OR NO*
HIGH BLOOD PRESSURE	*YES OR NO*	*FREQUENT HEADACHES*	*YES OR NO*
LOW BLOOD PRESSURE	*YES OR NO*	*EAR INFECTIONS*	*YES OR NO*
ASTHMA	*YES OR NO*	*RHEUMATIC FEVER*	*YES OR NO*
TUBERCULOSIS, LUNG AILMENTS	*YES OR NO*	*HEART MURMUR*	*YES OR NO*
LIVER PROBLEMS, HEPATITIS	*YES OR NO*	*ANEMIA*	*YES OR NO*
VENEREAL DISEASE	*YES OR NO*	*DIABETES*	*YES OR NO*
EYE TROUBLES	*YES OR NO*	*AIDS*	*YES OR NO*
KIDNEY PROBLEMS	*YES OR NO*	*NERVOUS COMPLAINTS*	*YES OR NO*
ARTHRITIS	*YES OR NO*	*LOSS OF CONSCIOUSNESS*	*YES OR NO*

ALLERGIES:

HAY FEVER	*YES OR NO*	*IODINE YES OR NO*	*FOOD YES OR NO*
PENICILLIN	*YES OR NO*	*SULFAMIDES YES OR NO*	
LATEX	*YES OR NO*	*METAL YES OR NO*	*ASPIRIN YES OR NO*
LOCAL ANESTHETICS YES OR NO			

OTHER ALLERGIES IF ANY: _____

HAVE YOU RECEIVED CANCER TREATMENT OF ANY KIND? YES OR NO
HAVE YOU HAD ANY SURGERY? YES OR NO
PLEASE LIST: _____

LIST OF ANY MEDICATIONS YOU ARE PRESENTLY TAKING: _____

_____

_____

_____

_____

_____

LADIES:

ARE YOU IN YOUR MENOPAUSE?	*YES OR NO*
DO YOU TAKE BIRTH CONTROL PILLS	*YES OR NO*
ARE YOU PREGNANT	*YES OR NO*

Date: _____

Signature: _____