## MEDICAL HISTORY

FOR

NAME :

Birth Date:

Diabetes	Are you und		Van Chie	ves places suplais:			
Have you ever had a serious head or neck injury? Yes No If yes, please explain:  Are you taking any medications, pills, or droys Yes No Do you taken. Phen-Fen or Redux? Yes No Are you on a special diet? Yes No Do you use tobstaces? Yes No Do you use controlled substances? Yes No Norman Yes No Benarity Medical Properties of the following?    Aspirim   Penicillim   Codeine   Acrylic   Metal   Latex   Local Anesthetics			Tes No II	yes, please explain:			
Are you taken, Phen-Fen or Reductive? Yes No Are you on a special diet? Yes No Do you use controlled substances? Yes No Ornen: Are you eignant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Prougle and the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  Other If yes, please explain: Other If yes, p	e you ever been hospitalized	or had a major operation?	Yes No II	yes, please explain:			
Are you taken, Phen-Fen or Reductive? Yes No Are you on a special diet? Yes No Do you use controlled substances? Yes No Ornen: Are you eignant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Prougle and the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  Other If yes, please explain: Other If yes, p	Have you ever had a se	erious head or neck injury?	Yes No If	yes, please explain:			
Do you take, or have you taken, Phen-Fen or Redux? Yes No	Are you taking any m	nedications, pills, or drugs?	Yes No If	yes, please explain:			
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Do you use tobacco? Yes No Do you use controlled substances? Yes No Omen: Are you genant/Tyring to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No reyou allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  Other If yes, please explain:  yo you have, or have you had, any of the following? SoftHV Poellive Yes No Diabetes Yes No			Yes No				
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heimer's Disease Yes No Drug Addiction Yes No Hepatitis A Yes No Hepatitis A Yes No Hepatitis B or C Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Trouble/Disease Yes N			O Yes O No I	Hemophilia	O Yes O No	Renal Dialysis	O Yes O N
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Excessive Thirst				Hypoglycemia	Yes No	Sinus Trouble	Yes N
thms			7 7	11 7.7	Yes No	Spina Bifida	Yes 1
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remotherapy lest Pains			Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	=
lest Pains		No Hay Fever	Yes No	Pain in Jaw Joints	Yes No		
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Accent Weight Loss Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Yes No Recent Weight Loss Yes No Recent Weig	old Sores/Fever Blisters Yes	No Heart Murmur	O Yes O No	Psychiatric Care			X X
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