MEDICAL INFORMATION:

Are you in good health at the present time? YES NO

If answer no, please explain. ______________________________

Are you presently or have you recently been under the care of any other physician? ______________________________

Please list who your Primary care Physician or your family doctor is. Please list their address & telephone number:

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Have you been under the care of any physician for any medical or surgical condition in the last 5 years? If so, please list physician and condition treated for: ______________________________

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Please list all surgery, including cosmetic surgery that you have had including the dates:______________________________

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Please list medications that you are currently taking. Including aspirin or ibuprofen. Please include dosages, frequency and the reason for taking the medication:______________________________

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Do you have any known allergies: If so , please list:______________________________

Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:

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Do you smoke? If so, how many packs per day? __________________ Or per week ______________________
Do you drink alcohol? If so how many glasses a day? ______________ Or per week ______________________
For Women: Is there a possibility that you are pregnant? YES NO
When was your last general exam? ______________________________

Do you suffer from any of the following:
Asthma, Chronic Bronchitis, or other lung problems? YES NO
Heart Disease, including Angina, Arrhythmia's. or prior heart attacks? YES NO
Diabetes? YES NO
Kidney Disease? YES NO
Hepatitis, or other liver disease? YES NO
Peptic Ulcers? YES NO
Ulcerative Colitis or other intestinal problems? YES NO
Lupus, Seleroderma, or other autoimmune diseases? YES NO
Bleeding disorder or prolonged with surgery/dental work? YES NO
HIV or other communicative diseases? YES NO
Anxiety/Psychological disorder? YES NO
Other significant medical problems? ______________________________

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