

## Form #2 - Patient Medical History

Physician

Office Phone

Date of Last Exam

1. Are you under medical treatment now?

2. Have you ever been hospitalized for any surgical [ operation or serious illness within the last 5 years?

If yes, please explain

3. Are you taking any medication(s) including [ non-prescription medicine?

If yes, what medication(s) are you taking?

4. Have you ever taken Phen-Fen/Redux?

5. Do you use tobacco?

6. Do you use controlled substances?

7. Are you wearing contact lenses?

8. Do you have or have you had any of the [ following?

High Blood Pressure

Heart Attack

Rheumatic Fever

Swollen Ankles

Fainting/Seizures

Asthma

Low Blood Pressure

Epilepsy/Convulsions

Leukemia

Diabetes

Kidney Diseases

AIDS or HIV Infection

Thyroid Problem

Recent Weight Loss

Respiratory Problems

Heart Disease

Cardiac Pacemakert

Heart Murmur

Angina

Frequently Tired

Anemia

Joint Replacement or Implant

Hepatitis/Jaundice

Sexually Transmitted Disease

Stomach Trouble/Ulcers

Liver disease

Other

9. Are you allergic to have you had any [ reactions to the following:

Local Anesthetics (e.g. novocain)

Penicillin or any other Atibiotics

Sulfa Drugs

Barbiturates

Sedatives

Iodine

Aspirin

Any metals (e.g. nickel, mercury, etc.)

Latex Rubber

Other

10. Women Only:

a) Are you pregnant or think you may be [ pregnant?

b) Are you nursing?

c) Are you taking oral contraceptives?

Emphysema

Cancer

Arthritis

Chest Pains

Easily Winded

Stroke

Hay Fever/Allergies

Tuberculosis

Radiation Therapy

Glaucoma

Heart Trouble

Mitral valve Prolapse