MEDICAL HISTORY

Are you currently under a physician's care?	Y	N
When was your last physical exam?		
Please list all medications:		
Are you allergic to any medications or substances? If yes, please list:	Y	N
Do you have asthma or other breathing problems?	Y	N
Have you ever had rheumatic fever?	Y	N
Are you aware of any heart murmur or congenital heart defect?	Y	N
Do you have high blood pressure?	Y	N
Do you have a pacemaker or artificial heart valve?	Y	N
Do you have any blood disorders such as anemia, leukemia, etc?	Y	N
Have you ever bled excessively after being cut or injured?	Y	N
Have you ever had a serious illness or major surgery? If yes, please list:	Y	N
Have you ever had radiation treatment to your head or neck?	Y	N
Do you have arthritis or rheumatism?	Y	N
Do you have any artificial joints, implants or prostheses?	Y	N
Do you have any stomach problems?	Y	N
Do you have any kidney problems?	Y	N
Do you have any liver problems?	Y	N
Are you a diabetic?	Y	N
Do you have epilepsy or seizure disorder?	Y	N