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CORE MEDICAL HISTORY

1. Are you now or have you been under the care of a physician during the past five years? Yes _____ No _____

2. Do you take any medications regularly? Yes _____ No _____

3. Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy? Yes _____ No _____

4. Have you ever had any breathing difficulties such as asthma, emphysema, chronic cough, tuberculosis, or any other lung disorder? Yes _____ No_____

5. Have you ever had any of the following illnesses? If so, please check.

_____ Heart trouble	_____ Kidney disease
_____ Stroke	_____ High or low blood pressure
_____ Rheumatic fever	_____ Diabetes
_____ Hepatitis or liver trouble	_____ Anemia

6. Are you subject to prolonged bleeding? Yes_____ No _____

7. Are you sensitive or allergic to any drug such as penicillin, aspirin, novocaine, or codeine? Yes_____ No _____

8. Do you have a cold, cough, or sinus trouble? Yes_____ No _____

9. Have you had anything to eat or drink in the pas six hours? Yes_____ No_____

10. Do you wear contact lenses? Yes_____ No _____

11. Are you pregnant? Yes_____ No _____

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SIGNATURE DATE