NAME ______________________________ NICK NAME _____________________________

DOB _________________

MEDICAL HISTORY

YES	NO	
☐	☐	Are you currently taking any drugs or medications? ___________________________
☐	☐	Are you allergic to any drugs or medications? _______________________________
☐	☐	In the past two years, have you extensively travelled or lived outside the U.S.? ____

To the best of your knowledge are you, or have you ever been afflicted with:

- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Respiratory disease
- ☐ Blood disorders
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart attack/ angina
- ☐ Epilepsy
- ☐ Kidney disease
- ☐ Acquired Immunodeficiency Disease
- ☐ Mouth ulcers
- ☐ Tumors or Cancer
- ☐ Yellow jaundice
- ☐ Unusual weight loss
- ☐ Low grade fevers
- ☐ Stomach ulcers

Physician ___________________________________ Phone ______________________

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND VALID.

Signature __________________________________ Date ________________________