Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Yes No If yes, please explain: Do you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: Do you take or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: Do you use tobacco? Yes No If yes, please explain: Do you take Aspirin? Yes No If yes, please explain: Do you take Aspirin? Yes No If yes, please explain: Do you take Aspirin? Yes No If yes, please explain: Do you take Aspirin? Yes No If yes, please explain: Do you take Aspirin? Yes No If yes, please explain: Do you take Aspirin? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Yes No If yes, please explain: Do you have an Artificial Joint? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? AlDS/HIV Positive Yes No Doug Addiction Yes No Hepatilis A Yes No Renal Dialysis Yes Angelia Anemia Yes No Emphysema Yes No Hepatilis Bor C Yes No Rheumatism Yes Anemia Yes No Emphysema Yes No Hepatilis Bor C Yes No Shingles Yes Angelia Anemia Yes No Emphysema Yes No Hepatilis Bor C Yes No Shingles Yes Antificial Joint Yes No Emphysema Yes No Hepatilis Port Yes No Shingles Yes Antificial Joint Yes No Emphysema Yes No Hepatilis Port Yes No Shingles Yes No Shingles Yes Antificial Joint Ye		cian's	care n	ow?	Yes	No	Physicians Name:					_
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Birth Date _____

PATIENT NAME _____