MEDICAL HISTORY

1) Are you now or have you been under a physician's care during the past two years ? _____
   If yes, for what reason ? _____
   NAME OF M.D. _____
2) Have you taken any kind of medication or drugs during the past year ? _____
   If yes, what? _____
3) Are you taking medication now? _____
   If yes, what? _____
4) Have you taken steroids? (Example: Cortisone) _____
5) Do you have any allergies to medications? _____
6) Do you bleed excessively after a cut, wound, surgery or tooth extraction ? _____
7) Do you smoke? _____
   If yes, how much and for how long? _____
8) Do you drink alcoholic beverages ? _____
   If yes, how much? _____
9) Have you ever had any breathing difficulty, such as chronic cough, bronchitis, emphysema, pneumonia, T.B. or other lung disorders? _____
10) Check any of the following which you now have or have had in the past: _____

_____	HEART TROUBLE	_____	THYROID DISEASE
_____	CONGENITAL HEART LESIONS	_____	KIDNEY DISEASE
_____	HEART MURMUR	_____	ANEMIA
_____	RHEUMATIC FEVER	_____	IMMUNOSUPPRESSANT DISORDER
_____	HIGH BLOOD PRESSURE	_____	EPILEPSY OR SEIZURE DISORDERS
_____	STROKE	_____	PSYCHIATRIC TREATMENT
_____	DIABETES	_____	HEPATITIS OR LIVER DISEASE
_____	GLAUCOMA	_____	CONTACT LENSES
_____	ASTHMA	_____	DIFFICULTY WITH AN ANESTHETIC
_____	PROSTHETIC HIP	_____	BRUISE EASILY
_____	PREVIOUS HEART ATTACK	_____	CANCER
_____	CHEST PAIN (ANGINA)	_____	AIDS OR HIV INFECTION
_____	JAW CLICKING AND/OR PAIN WHEN EATING	_____	IRREGULAR HEART BEAT
		_____	SEXUALLY TRANSMITTED DISEASES

ANY OTHER DISEASES NOT MENTIONED ABOVE? _____

11) Women: Are you pregnant now? _____ Are you nursing? _____
    Are you taking birth control pills? _____

WOMEN NOTE : Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I grant permission to Dr. Kaplan to perform an examination and take x-rays if necessary.

Signature of Patient: _____ Date: _____

I acknowledge that a posted copy of this office's Notice of Privacy Practices has been made available to me to read. A copy of this notice will also be provided to me upon my request.

Signature of Patient: _____ Date: _____