

Patient Medical History

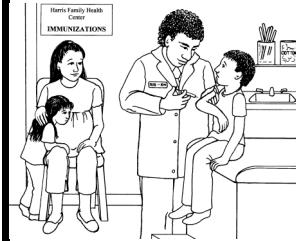
1. Date of last medical exam _____

2. Have you ever been hospitalized for surgery or serious illness?
___ Yes ___ No

If yes, _____

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____

3. Are you taking any medications?
___ Yes ___ No



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