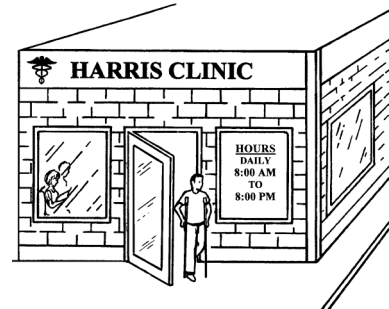


hospital



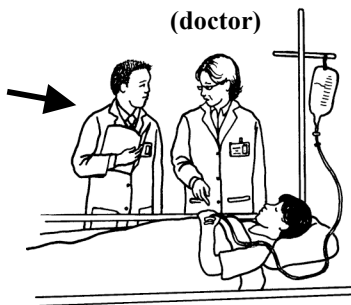
clinic



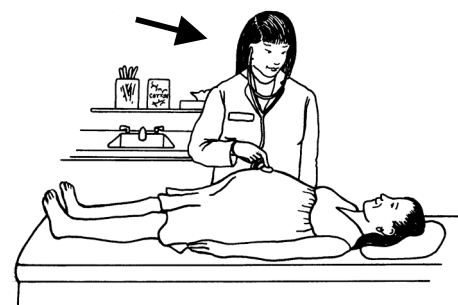
doctor/physician



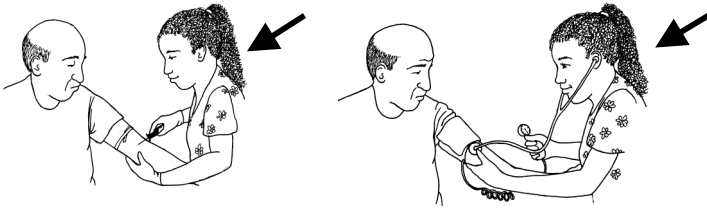
examine you



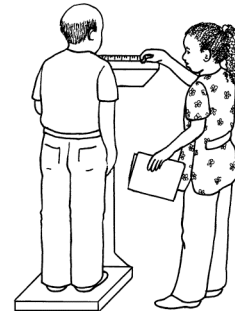
physician assistant



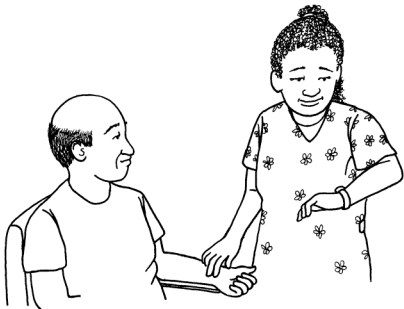
nurse practitioner



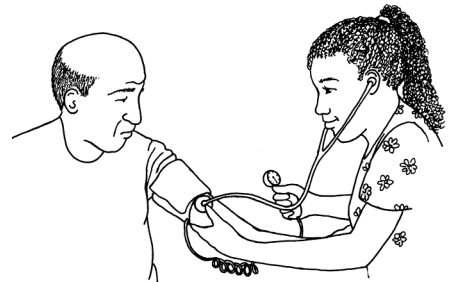
nurse



weight



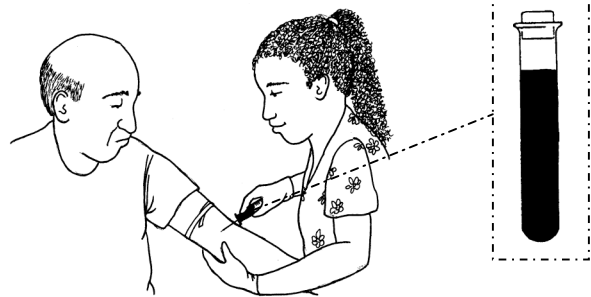
pulse



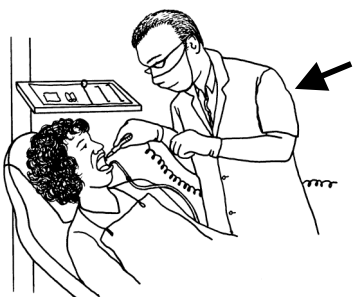
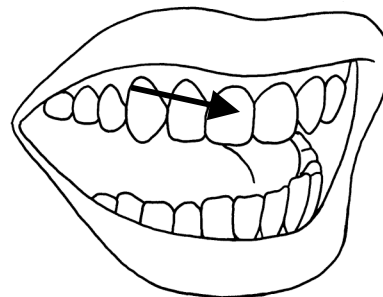
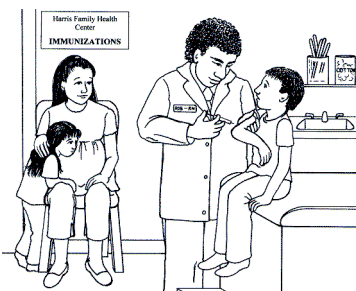
blood pressure



shot



test

**dentist****teeth****appointment****dental hygienist / dental assistant****preventive checkup**

Family 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 _____		

immunization