DIAMONDSMILES Medical History

Patient Name _____________________

Physician's Name ______________________ Telephone __________________
Physician's Address ______________________
____

Women. Are you pregnant? No ___ Yes ___ Months ____
Have you ever been admitted to a hospital? Yes ___ No ___
If yes, please explain: ____
____

Do you drink alcohol? Yes ___ No ___. If yes, how much? _____________________
Do you smoke? Yes ___ No ___. If yes, how much? _____________________
Do you use drugs? Yes ___ No ___. If yes, what type? _____________________

Do you have, or have you had, any of the following:

Heart (surgery, disease)	Yes No	Ulcers	Yes No	Hepatitis	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Defect	Yes No	Thyroid Disease	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact Lenses	Yes No	Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Jaundice	Yes No
Swollen Ankles	Yes No	Sinus Trouble	Yes No	Paralysis	Yes No
Stroke	Yes No	Cancer	Yes No	Epilepsy	Yes No
Special Diet	Yes No	Radiation	Yes No	Faints/Spells	Yes No
Artificial Joints	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric Care	Yes No

Do you have, or have you had, any illness, disease, or condition not listed? Yes __ No __
If yes, please explain: ____
____

Do you have any allergies? Yes __ No __
If yes, please list: ______________________ ________________________
______________________ ________________________
______________________ ________________________

Are you currently taking any pills, medications, or drugs? Yes __ No __
If yes, please list: ______________________ ________________________
______________________ ________________________
______________________ ________________________