Place a mark on yes or no to indicate if you have had any of the following:

Anemia	☐Yes	☐No	Artificial Joints	☐Yes	☐No
Angina Pectoris	☐Yes	☐No	Asthma	☐Yes	☐No
Any Implants	☐Yes	☐No	Bruise Easily	☐Yes	☐No
Any Transplant	☐Yes	☐No	Cancer	☐Yes	☐No
Arthritis	☐Yes	☐No	Hepatitis A	☐Yes	☐No
Drug Addiction	☐Yes	☐No	Hepatitis B or C	☐Yes	☐No
Eating Disorder	☐Yes	☐No	Herpes Simplex	☐Yes	☐No
Emphysema	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Hives or Skin Rash	☐Yes	☐No
Fainting/Dizziness	☐Yes	☐No	Jaundice	☐Yes	☐No
Glaucoma	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Heart Attack	☐Yes	☐No	Liver Disease	☐Yes	☐No
Heart Disease	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Heart Murmur	☐Yes	☐No	Pacemaker	☐Yes	☐No
Heart Surgery	☐Yes	☐No	Chemotherapy	☐Yes	☐No
Hemophilia	☐Yes	☐No	Chest Pains	☐Yes	☐No
Cold Sores	☐Yes	☐No	Congenital Heart	☐Yes	☐No
Dentures/Partials	☐Yes	☐No	Diabetes	☐Yes	☐No
Psychiatric Therapy	☐Yes	☐No	Radiation Therapy	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Sickle Cell Anemia	☐Yes	☐No	Sickle Cell Anemia	☐Yes	☐No
Stroke	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Tobacco Use	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Ulcers	☐Yes	☐No			

For Women:

Are you taking oral contraceptives? ☐Yes ☐No

Are you **pregnant** now? ☐Yes ☐No

If yes, when is your due date? _____

Are you currently breast-feeding? ☐Yes ☐No