Please attach another paper if needed

Name DOB Today's Date

Medical History:

Please describe any problems you have ever had with any of the listed topics:	USE THIS COLUMN TO DESCRIBE DETAILS OF YOUR Current and Past Medical Histo	USE THIS COLUMN TO DESCRIBE DETAILS OF FAMILY Medical history Father/Mother/Siblin s/Grand arents, etc
SKIN, HAIR, NAILS, TEETH Do ou wear dentures? Y N		
EYES, EARS, NOSE, THROAT Glasses Y N Hearin aid Y N		
HEART PROBLEMS? Have you had a heart attack? Y N Do you have high cholesterol? Y N Hi h blood ressure? Y N		Has anyone in your family had a heart attack? Y
LUNGS/BREATHING PROBLEMS? Y N		