Question about medical history No.

Name Tel( )

Birthday and age

Address

Occupation Tel( )

1. What is your problem?

( )

2.Have you ever had an injection for anesthesia?

Yes or No

3.Are you taking any from of medication regularly?

Yes or No

4.Do you have an allergy?

Yes or No ( )

5.Have you ever had a blood transfusion?

Yes or No

6.Do you have or have you ever had a disease of heart, liver, and kidney?

Yes or No ( )

7.Are you under a doctor's care now?

Yes or No ( )

8.For woman: Are you pregnant? Yes or No