MEDICAL HISTORY OF PATIENT
병력란을 상세히 기입해 주십시오

1. Your current physical health is: ☐Good ☐Fair ☐Poor
현재 건강상태:

2. Do you smoke or use tobacco in any other form? ☐Yes ☐No
흡연 중이십니까?

3. Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐Yes ☐No
드시는 약이 있으십니까?
* Which ones / 무엇입니까?

4. Have you ever taken Fosamax, or any other bisphophonate? ☐Yes ☐No
포사맥스나 골다공증 약품을 드신적이 있으십니까?

5. Have you ever taken Phen-Fen? ☐Yes ☐No
펜테르민/훼플루라민을 드신적이 있으십니까?

6. Are you under a physician's care now? ☐Yes ☐No
치료 중이십니까?
If so, please give reason for treatment:
무슨 치료를 받으십니까?
Physician's Name: Telephone:
의사이름: 전화번호:

For Women :

7. Are you using a prescribed method of birth control? ☐Yes ☐No
처방받은 경구 피임약을 복용 중이십니까?

8. Are you pregnant? ☐Yes ☐No
임신 중이십니까?
Week (몇주) #:

9. Have you ever had any of the following diseases or medical problems?

Y ☐ N ☐	Abnormal Bleeding 심한출혈	Y ☐ N ☐	Herpes / Fever Blisters 포진
Y ☐ N ☐	Alcohol / Drug Abuse 술/약물남용	Y ☐ N ☐	High Blood Pressure 고혈압
Y ☐ N ☐	Anemia 빈혈	Y ☐ N ☐	HIV+ / AIDS 에이즈
Y ☐ N ☐	Arthritis 관절염	Y ☐ N ☐	Hospitalized for Any Reason 입원
Y ☐ N ☐	Artificial Bones / Joints / Valves 인공뼈	Y ☐ N ☐	Kidney Problems 콩팥질환
Y ☐ N ☐	Asthma 천식	Y ☐ N ☐	Liver Disease 간장질환
Y ☐ N ☐	Blood Transfusion 수혈	Y ☐ N ☐	Low Blood Pressure 저혈압
Y ☐ N ☐	Cancer / Chemotherapy 암	Y ☐ N ☐	Lupus 낭창
Y ☐ N ☐	Colitis 대장염	Y ☐ N ☐	Mitral Valve Prolapse 승모판 탈출증
Y ☐ N ☐	Congenital Heart Defect 선천성 심장병	Y ☐ N ☐	Osteoporosis / Paget's Disease 골다공증
Y ☐ N ☐	Diabetes 당뇨병	Y ☐ N ☐	Pacemaker 인공 심장박동기
Y ☐ N ☐	Difficulty Breathing 호흡곤란	Y ☐ N ☐	Psychiatric Problems 정신병
Y ☐ N ☐	Emphysema 폐기종	Y ☐ N ☐	Radiation Treatment 방사선 요법
Y ☐ N ☐	Epilepsy 뇌전증	Y ☐ N ☐	Rheumatic / Scarlet Fever 류마치성열
Y ☐ N ☐	Fainting Spells 실신	Y ☐ N ☐	Seizures 뇌졸중
Y ☐ N ☐	Frequent Headaches 두통	Y ☐ N ☐	Shingles 대상 포진
Y ☐ N ☐	Glaucoma 녹내장	Y ☐ N ☐	Sickle Cell Disease/ Traits 겸상 적혈구성 빈혈
Y ☐ N ☐	Hay Fever 고초열	Y ☐ N ☐	Sinus Problems 코의 염증
Y ☐ N ☐	Heart Attack 심장마비	Y ☐ N ☐	Stroke 뇌졸중
Y ☐ N ☐	Heart Murmur 심잡음	Y ☐ N ☐	Thyroid Problems 갑상선
Y ☐ N ☐	Heart Surgery 심장수술	Y ☐ N ☐	Tuberculosis (TB) 결핵
Y ☐ N ☐	Hemophilia 혈우병	Y ☐ N ☐	Ulcers 궤양
Y ☐ N ☐	Hepatitis 간염	Y ☐ N ☐	Venereal Disease 성병

Please list any serious medical condition(s) that you have ever had:
건강에 대하여 참고 할 만한 사항 있으시면 기록하십시오:

10. Are you allergic to any of the following? / 이 중에서 알레르기가 있으십니까?

Y ☐ N ☐	Aspirin 아스피린	Y ☐ N ☐	Latex 라텍스
Y ☐ N ☐	Codeine 코데인	Y ☐ N ☐	Penicillin 페니실린
Y ☐ N ☐	Dental Anesthetics 치과 마취	Y ☐ N ☐	Tetracycline 테트라사이클린
Y ☐ N ☐	Erythromycin 에리스로마이신	Y ☐ N ☐	Other 기타

Please list any other drugs/materials that you are allergic to:
이 외에 알레르기 있으신 약들을 기록하십시오: