#1. PAST MEDICAL HISTORY

SURGERIES - HOSPITALIZATIONS :		INJURIES - FRACTURES	
_____	year _____	_____	year _____
_____	year _____	_____	year _____
_____	year _____	_____	year _____
_____	year _____	_____	year _____

#2. ALLERGIES - DRUG OR ENVIRONMENTAL

LIST ANY DRUG ALLERGIES	LIST ANY ENVIRONMENTAL ALLERGIES
_____	_____
_____	_____

#3. FAMILY MEDICAL HISTORY - parents and siblings

- ☐ Cancer
- ☐ Neurological Disorder
- ☐ Diabetes
- ☐ Strokes /TIA's
- ☐ Adopted/Unknown
- ☐ None of the Above
- ☐ Headaches
- ☐ Cardiac Disease Before Age 40
- ☐ Other:
- ☐ Heart Disease
- ☐ Psychiatric Disease

LIVING PARENTS?

Mother Living Deceased at age: _____ Cause of Death _____

Father Living Deceased at age: _____ Cause of Death _____

#4. SOCIAL AND OCCUPATIONAL HISTORY

Your Job Description: _____ Job Duties: _____

Recreational Activities / Hobbies: _____

#5. LIFESTYLE HABITS

- ☐ Current Smoker [ ] cigarettes p/day
- ☐ Former Smoker
- ☐ Marijuanna Use Frequency? _____
- ☐ Chewing Tobacco
- ☐ Alcohol
- ☐ Caffeine

Do you exercise on a regular basis? Yes ☐ No ☐ Type: _____ Frequency _____

Has your condition stopped you from exercise or other activities? Yes ☐ No ☐

How many hours of sleep do you average per night? _____ Do your symptoms affect your sleep? Yes ☐ No ☐

#6. Medications List [Prescriptions/Over the Counter/Vitamins]

You can provide a list at the front desk if you prefer

Name of Medication	Reason or Condition for this Medication