MEDICAL INFORMATION

NAME: _____ **DOB**: _____

Please list any medications you are taking (Please include over-the-counter medicines/supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list medical problems you have or have had in the past (i.e. diabetes, hypertension, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any operations and hospitalizations, approximate dates and reasons

_____

_____

_____

ALLERGIES:_____

Do you now, or have you ever had trouble with:

___ Headaches	___ Neck	___ Kidneys	___ Nervous System
___ Eyes	___ Back	___ Stomach	___ Depression
___ Ears	___ Breasts	___ Liver	___ Anxiety
___ Nose	___Lungs	___ Genitals-Urinary Sys	___ Alcohol
___ Mouth/Throat	___ Heart	___ Bones/Muscles	___ Drugs

Do you now or have you ever smoked? ___ Yes ___ No
If so, how much? _____ How long? _____ If you quit, when? _____

Do you drink alcohol? ___ Yes ___ No If so, how much? _____

Do you drink caffeine? ___ Yes ___ No If so, how much? _____

Do you exercise? ___ Yes ___ No If so, how often? _____

Is your Mother alive? ___ Yes ___ No Medical problems? _____
If no, age at death ____
Is your Father alive? ___ Yes ___ No Medical problems? _____
If no, age at death ____

Do you have brothers/sisters ___ Yes ___ No Medical problems? _____

Do you have any pertinent medical history not covered above? _____

_____