PATIENT MEDICAL HISTORY

PLEASE LIST CURRENT MEDICATIONS:

PLEASE LIST ALLERGIES/REACTIONS:

PLEASE LIST PREVIOUS SURGERIES/DATES:

HAVE **YOU** EVER BEEN DIAGNOSED WITH THE FOLLOWING?

ASTHMA	O Yes	O No
BLEEDING PROBLEMS	O Yes	O No
CANCER	O Yes	O No
DIABETES	O Yes	O No
DIGESTIVE DISORDERS	O Yes	O No
HEART PROBLEMS	O Yes	O No
HIV OR AIDS	O Yes	O No
HYPERTENSION	O Yes	O No
KIDNEY/BLADDER PROBLEMS	O Yes	O No
LUNG PROBLEMS	O Yes	O No
MENOPAUSE	O Yes	O No
NERVOUS SYSTEM PROBLEMS	O Yes	O No
THYROID PROBLEMS	O Yes	O No

HAS ANYONE IN **YOUR FAMILY** BEEN DIAGNOSED WITH THE FOLLOWING?

CANCER	O Yes	O No
HEART DISEASE	O Yes	O No
DIABETES	O Yes	O No
OTHER		

DO YOU SMOKE?	O Yes	O No
IF SO, HOW MANY PACKS PER DAY?	O More than 1	O Less than 1
HAVE YOU EVER SMOKED?	O Yes	O No
DO YOU USE ALCOHOL?	O Yes	O No
HAVE YOU EVER USED ALCOHOL?	O Yes	O No
HAVE YOU BEEN TREATED FOR DRUG/ALCOHOL ABUSE?	O Yes	O No
ARE YOU PREGNANT?	O Yes	O No
DO YOU HAVE CHILDREN?	O No O 1 O 2 O 3 O 4 O More than 4	
MARITAL STATUS?	O Single O Married O Divorced O Separated O Widowed	
ARE YOU A JEHOVAH'S WITNESS	O Yes	O No
IS THIS A WORK RELATED INJURY?	O Yes	O No
IF SO, WHAT WAS THE DATE OF INJURY?		
HAVE YOU NOTIFIED YOUR EMPLOYER?	O Yes	O No