Name: ______________________ Height: ______ Weight: ______ Age: ______ Today's Date: ______

## SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Is there someone at home able to take care of you? ❑ Yes ❑ No

Alcohol: ❑ Social Drinker ❑ Heavy Drinker ❑ Occasional ❑ Never Tobacco: Number of packs per day__________

How much time have you lost from work due to health problems during the past 6 months? ______ 1 yr. ______ 3 yrs. ______

## FAMILY HISTORY - HAS ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Mental Illness | ❑ | ❑ | Thyroid Disease | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ | Stroke | ❑ | ❑ | Bleeding Tendencies | ❑ | ❑ | Ulcers | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Convulsions | ❑ | ❑ | Arthritis | ❑ | ❑ | | | |
| Heart Condition | ❑ | ❑ | Suicide | ❑ | ❑ | Kidney Condition | ❑ | ❑ | | | |

## ALLERGIES AND MEDICATIONS

Do you have any allergies to medications? ❑ Yes ❑ No Any other medically related allergies? ❑ Yes ❑ No

If yes, please specify: ______________________

Are you currently taking any medication? ❑ Yes ❑ No

If yes, what type(s): ______________________

## PERSONAL HISTORY - HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE ANSWER YES OR NO TO ALL QUESTIONS)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Frequent or severe headache | ❑ | ❑ | 21. Abnormal blood pressure | ❑ | ❑ |
| 2. Dizziness or fainting spells | ❑ | ❑ | 22. Heart problem or murmur | ❑ | ❑ |
| 3. Eye problem | ❑ | ❑ | 23. Excessive bleeding | ❑ | ❑ |
| 4. Ear, nose or throat problem | ❑ | ❑ | 24. Anemia or other blood condition | ❑ | ❑ |
| 5. Chest or lung problem | ❑ | ❑ | 25. Clots in legs or vein problem | ❑ | ❑ |
| 6. Tuberculosis | ❑ | ❑ | 26. Stomach, liver or intestinal problems | ❑ | ❑ |
| 7. Swelling of extremities / shortness of breath | ❑ | ❑ | 27. Hepatitis, jaundice or gall bladder problem | ❑ | ❑ |
| 8. Pain or pressure in chest | ❑ | ❑ | 28. Ulcer | ❑ | ❑ |
| 9. Palpitation or pounding heart | ❑ | ❑ | 29. Urinary, kidney, bladder or prostate problem | ❑ | ❑ |
| 10. Tumor, growth or cancer | ❑ | ❑ | 30. Muscle weakness / atrophy | ❑ | ❑ |
| 11. Recent gain or loss of weight over 10 lbs. | ❑ | ❑ | 31. Neuromuscular / neurological problems | ❑ | ❑ |
| 12. Diabetes | ❑ | ❑ | 32. Drinking dependency / disorder | ❑ | ❑ |
| 13. Epilepsy | ❑ | ❑ | 33. Drug dependency / disorder | ❑ | ❑ |
| 14. Measles, Mumps or Chicken Pox | ❑ | ❑ | 34. Psychological problems | ❑ | ❑ |
| 15. Scarlet or Rheumatic Fever | ❑ | ❑ | 35. Surgeries / serious illness | ❑ | ❑ |
| 16. Arthritis, Gout or Rheumatism | ❑ | ❑ | 36. Notable accidents / injuries | ❑ | ❑ |
| 17. Fractures, sprains or dislocations | ❑ | ❑ | 37. Skin diseases | ❑ | ❑ |
| 18. Painful or swollen joints | ❑ | ❑ | 38. Pregnant, or possible pregnant at present | ❑ | ❑ |
| 19. Bone infections | ❑ | ❑ | 39. Obstetrical disorders | ❑ | ❑ |
| 20. Taken steroids | ❑ | ❑ | | | |

Please explain any yes answers. Be sure to number each explanation with the item number.

______________________

______________________

______________________

______________________

Other medical problems: ______________________

Past surgeries: ______________________

Part of body injured or effected: ______________________ ❑ Right ❑ Left

When and how did this occur: ______________________

Any surgery for current problem? ❑ Yes ❑ No ______________________