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