Name: ________________________________ Date: ______________

DOB: ______________ PRIMARY CARE PHYSICIAN: ___________________________

HAVE YOU EVER HAD PROBLEMS WITH: (CHECK YES OR NO)

YES	NO			YES	NO
		EYE DISEASE	HEART PROBLEMS / CARDIOVASCULAR PROBLEMS		
		RASHES / SKIN DISEASE	GENITOURINARY DISEASE		
		BONE/MUSCLE / JOINT DISEASE	BLOOD DISEASE		
		GLANDULAR / ENDOCRINE	IMMUNE SYSTEM DISEASE		
		HEADACHES / INJURIES/ HEAD & NECK PROBLEMS	NECK DISEASE		
		EARS, NOSE, MOUTH OR THROAT DISEASE	BREATHING PROBLEMS		
		BREAST TUMORS OR DISEASE	NERVOUS SYSTEM DISEASE		
			PSYCHIATRIC DISEASE		
			GASTROINTESTINAL DISEASE		

PAST HISTORY:

Current Medications: ____

____

Prior Major Illnesses & Injuries: ____

Prior Operations/Hospitalizations: ____

Allergies: ____

Age-Appropriate Immunization Status (flu, tetanus, etc.): _________________________________

Family Medical History: ____

____

SOCIAL HISTORY:

Marital Status: Married Single Widowed Other: __________________

Current and Past Employment: ____

Recreational History: ____

Use of Drugs, Alcohol, Tobacco, & Over-The-Counter Medications: _________________________

Living Arrangements (own home, assisted living, nursing home, etc.): ______________________

Extent of Education: ____

Travel (out of the country, if so, where): ____

Armed Services: ___________________________ Toxin Exposure: ___________________________