HISTORY (Answers to these questions are for our records only and will be confidential)

Have you had a recent exam? Yes_____ No____ Date & Place:_____
Are you now under a Doctor's Care?_____
Have you been hospitalized within the past 5 years? Yes____ No_____ Reason_____
Have you ever had an operation? Yes____No_____ If so, please list:

Do you smoke? Yes____No_____ How Much?_____
Do you drink? Yes_____No_____ How Much?_____
Are you taking any medication now? Yes_____No_____ Please List:

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Are you allergic to sensitive to anything? Yes_____No_____ Please List:
Are you on anti-coagulant therapy(blood thinner) Yes____No_____
Have you ever taken steroids (cortisone) Yes____No_____
Have You Ever Had:

Tuberculosis	Yes	No	Dizzy Spells	Yes	No
Heart Trouble	Yes	No	Swollen Ankles	Yes	No
Rheumatic Fever	Yes	No	Frequent Urination	Yes	No
Heart Murmur	Yes	No	Excessive Thirst	Yes	No
High Blood Pressure	Yes	No	Bloody Urine	Yes	No
Diabetes	Yes	No	Large Glands	Yes	No
Heart Attack	Yes	No	Muscle Weakness	Yes	No
Thyroid Trouble	Yes	No	Weight Loss	Yes	No
Liver Trouble	Yes	No			
Kidney Trouble	Yes	No	**FAMILY HISTORY:**		
Stomach Trouble	Yes	No			
Nervous Trouble	Yes	No	HAS ANY FAMILY MEMBER HAD:		
Lung Trouble	Yes	No	Hearing Loss	Yes	No
Bowel Trouble	Yes	No	Dizzy Spells	Yes	No
Arthritis	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Heart Trouble	Yes	No
Venereal Disease	Yes	No	High Blood Pressure	Yes	No
Asthma(Hay Fever)	Yes	No	Diabetes	Yes	No
Glaucoma	Yes	No	Birth Defects	Yes	No
Headaches	Yes	No	Kidney Disease	Yes	No
Convulsions	Yes	No	Liver Disease	Yes	No
Bleeding Problems	Yes	No	Cancer	Yes	No
Shortness of Breath	Yes	No	Thyroid Cancer	Yes	No
Trouble Swallowing	Yes	No			
WOMEN: Are you pregnant?	Yes	No	**OTHER ILLNESS NOT SPECIFIED:**		
Are you taking birth control pills?	Yes	No			

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NAME: DOB:

SIGNATURE: DATE: