_____/_____/_____ _____

DOB AGE LAST NAME FIRST NAME M.I.

MARITAL STATUS: **S**ingle **M**arried **D**ivorced **W**idowed OCCUPATION_____
(CIRCLE)

# PAST MEDICAL HISTORY

1. ARE YOU ALLERGIC TO ANY MEDICINE, FOOD, OR SERUM? IF YES, PLEASE LIST THEM
☐ YES ☐ NO _____

2. DO YOU TAKE ANY MEDICINES REGULARLY? PLEASE NAME THEM, LIST DOSAGE AND INDICATION (why you take them)
☐ YES ☐ NO **(List Medicine Name / Dosage / Indication):** _____/_____/_____
_____/_____/_____, _____/_____/_____, _____/_____/_____
_____/_____/_____, _____/_____/_____, _____/_____/_____
_____/_____/_____, _____/_____/_____, _____/_____/_____
PLEASE USE THE BACK OF THIS SHEET IF YOU NEED MORE SPACE

3. HAVE YOU HAD ANY OPERATIONS? PLEASE STATE KIND OF OPERATION AND DATE
☐ YES ☐ NO _____

4. HAVE YOU HAD ANY BROKEN BONES OR OTHER ORTHOPAEDIC INJURIES? PLEASE LIST THEM
☐ YES ☐ NO _____

6. HAVE YOU BEEN DIAGNOSED WITH HIV AND/OR AIDS?
☐ YES ☐ NO

7. HAVE YOU EVER BEEN DIAGNOSED WITH HEPATITIS?
☐ YES ☐ NO

8. HAVE YOU BEEN DIAGNOSED WITH ASTHMA?
☐ YES ☐ NO

9. HAVE YOU EVER BEEN DIAGNOSED WITH DIABETES?
☐ YES ☐ NO

10. HAVE YOU BEEN DIAGNOSED WITH STOMACH ULCERS OR ACID REFLUX?
☐ YES ☐ NO

11. HAVE YOU EVER BEEN DIAGNOSED WITH RHEUMATOID ARTHRITIS?
☐ YES ☐ NO

12. HAVE YOU EVER BEEN DIAGNOSED WITH A DEEP VEIN THROMBOSIS( D.V.T.) OR BLOOD CLOT?
☐ YES ☐ NO IF YES, WHAT BODY AREA: _____

13. HAVE YOU BEEN DIAGNOSED WITH CANCER
☐ YES ☐ NO IF YES, LIST TYPE: _____

## SOCIAL HISTORY

14. ☐ YES ☐ NO ARE YOU A RECOVERING ADDICT AND/OR ALCOHOLIC?
15. ☐ YES ☐ NO DO YOU DRINK ALCOHOLIC BEVERAGES?

16. SMOKING STATUS: ☐ CURRENT SMOKER ☐ FORMER SMOKER ☐ NEVER SMOKED

## FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

17. ☐ YES ☐ NO TUBERCULOSIS
18. ☐ YES ☐ NO HEART DISEASE
19. ☐ YES ☐ NO CANCER
20. ☐ YES ☐ NO DIABETES
21. ☐ YES ☐ NO EPILEPSY
22. ☐ YES ☐ NO RHEUMATOID ARTHRITIS