Date:_____ Name:_____ Date of Birth:___/___/___
Age:____ Occupation:_____ Company:_____
Marital Status: Single__ Married__ Divorced__ Widowed__ Live Alone__
Religion:_____ Previous Physician:_____

A. PAST MEDICAL HISTORY

1a. Do you have or have you ever had any of the following (# of years in blank):
Heart Disease___ Ulcers___ Diabetes___ High Blood Pressure___
Stroke___ Cancer___ Arthritis___

1b. List any other serious medical illnesses you have had, including date of diagnosis. _____

_____

_____

2. List any operations you have had, incuding dates if known. _____

_____

_____

3. Have you ever had a blood transfusion? YES___ NO___ If yes, what year?_____

B. MEDICATIONS AND ALLERGIES AND NUTRITIONAL SUPPLEMENTS

1. List medications now taken regularly. _____

_____

2. List nutrirional supplements now taking (vitamins, minerals, herbs, homeopathic, etc.). _____

_____

3. Are you allergic or sensitive to any medicines? If so, please list. _____

_____

4. Do you have any food allergies? _____
5. Do you have any environment allergies? _____

C. IMMUNIZATIONS

Estimate the date and place of your last shot in the blank:
Tetanus_____ Measles/Mumps/Rubella_____ Influenza_____
Polio_____ Pneumovax_____ Hepatitus_____

D. HABITS

1. Have you ever smoke cigarettes? YES___ NO___ If yes, do you smoke now? YES___ NO
   a. If so, how many cigarettes do you (or did you) smoke per day? _____
   b. How long have/had you smoke? _____
   c. Do you use an other form of tobacco? YES___ NO___ If yes, what forms? _____
   d. Would you like to quit? YES___ NO___
2. Do you drink alcohol? YES___ NO___ If yes, how often? _____
3. Have you ever used/abused drugs? YES___ NO___ If so, which drug(s) and what dates? _____

_____

4. Are you on a special diet? YES___ NO___ If yes, what type of diet? _____
   a. Do you think you eat nutritiously? YES___ NO___
   b. Would you like to have diet counseling? YES___ NO___
5. Do you exercise regularly? YES___ NO___
   a. What type of exercise do you prefer? _____
   b. Is your weight stable? YES___ NO___
   c. Do you know your cholesterol level? YES___ NO___ If yes what is it? _____
   d. Do you know your trigliceride level? YES___ NO___ If yes, what is it? _____
6. Are you sexually active? YES___ NO___ With: Men___ Women___ Both___
   Total number of sexual partners?
7. Are you using birth control? YES___ NO___ What type?_____

(go to opposite side)