Medical History

Name: _____ Date of Birth: _____

Have you ever been treated for any of the following medical problems? (Please Circle)

High Blood Pressure	Diabetes	Depression
Heart Disease	Thyroid Disorders	Anemia
High Cholesterol	Liver Disease	Cancer
Lung Disease	Kidney Disorders	Muscular Disorder
Stomach/Intestinal Disorder		Nerve Disorder

Current Medications:

_____
_____
_____

Hospitalization:

_____
_____
_____

Have any of your relatives been diagnosed or treated for any of the following? (Please Circle)

Colon Cancer	Heart Disease	Diabetes
Prostate Cancer	High Blood Pressure	Thyroid Disorder
Breast Cancer	High Cholesterol	Seizures
Leukemia/Lymphoma	Stroke	Bleeding Disorders

Social History:

Marital Status: Married Single Divorced Widowed Live with Significant Other
Do you use tobacco? YES NO How Much? _____ How Long? _____
Did you use tobacco in the past? YES NO When did you quit? _____
Do you use alcoholic beverages? YES NO Type and Weekly Amount _____