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PAST MEDICAL HISTORY

General condition of health: Good___ Fair___ Poor___

If not good, please explain:_____
_____

Height_____ Weight_____ Recent weight change_____

How long ago was your most recent check-up? _____ Chest X-ray_____
Did the check-up include and EKG_____ Name of the Doctor_____

Serious Illnesses (please list)_____
_____
_____

Previous Surgeries (please list the procedure and date)
_____
_____
_____

Have you had significant complications from any of these operations? No____ Yes____
If "yes", please explain_____
_____
_____

Past Injuries (please list type and date)_____
_____
_____

MEDICATIONS AND DRUGS

What is your consumption of the following: Coffee or Tea _____
Tobacco_____ Alcohol_____

Please list <u>all</u> medications you are currently taking and their dosages:
_____
_____
_____

Are you allergic to any medications? No___ Yes___ If yes, please list_____
_____
_____

FAMILY HISTORY

	Age	State of Health
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Has any relative had:

	No	Yes	Relationship
Tuberculosis	__	__	_____
Cancer	__	__	_____
Diabetes	__	__	_____
Epilepsy	__	__	_____
Heart Disease	__	__	_____
High Blood Pressure	__	__	_____
Lung Disease	__	__	_____
Kidney Disease	__	__	_____
Blood or Bleeding Disorder	__	__	_____
Asthma	__	__	_____
Mental Disease	__	__	_____

Additional Comments _____

_____