NAME:_____ SS#:_____ DATE of BIRTH:_____ AGE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PHONE(home):_____ CELL:_____ EMAIL:_____

EMERGENCY CONTACT:_____ REALTIONSHIP TO YOU:_____ PHONE:_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? **YES / NO** (PLEASE CIRCLE) **DATE:**_____

PLEASE LIST **ALL** THE CURRENT MEDICATIONS YOU ARE TAKING:

1._____	5._____	9._____	13._____
2._____	6._____	10._____	14._____
3._____	7._____	11._____	15._____
4._____	8._____	12._____	16._____

DRUG ALLERGIES:	**YES / NO**	**If yes, what happens?**
Latex, Adhesive Tape	_____	_____
Penicillin	_____	_____
Other Antibiotics	_____	_____
Empirim, Tylenol	_____	_____
Aspirin, Advil, Aleve, or Motrin	_____	_____
Celebrex	_____	_____
Other Pain Remedies	_____	_____
Morphine	_____	_____
Codeine	_____	_____
Demerol	_____	_____
Other Narcotics	_____	_____

OTHER:_____

_____

FAMILY HISTORY:

List the relationship to you of family members who have had:

HEART DISEASE	_____
HIGH BLOOD PRESSURE	_____
STROKE	_____
CANCER	_____
GLAUCOMA	_____
DIABETES	_____
EPIELSY/CONVULSIONS	_____
BLEEDING DISORDER	_____
KIDNEY DISEASE	_____
THYROID DISEASE	_____
MENTAL ILLNESS	_____
OSTEOPOROSIS	_____
BIRTH DEFECTS	_____

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

High Blood Pressure_____	Lactose Intolerance_____	Heart Attack _____	Scarlet Fever _____
Shortness of breath _____	Gallbladder Disease_____	Poor Circulation _____	Chronic Rashes _____
Any Heart Condition_____	Prostate Disease _____	Liver Disease _____	Rheumatic Fever _____
Chest pain _____	Phlebitis _____	Lung Disease _____	Mumps _____
Dizziness/Fainting _____	Anemia _____	Nerve Disorder _____	Rubella _____
Vascular Disease _____	Diabetes _____	Tuberculosis _____	Polio _____
Headache _____	Gout _____	Thyroid Problem _____	Diphtheria _____
Asthma _____	Sciatica _____	Pneumonia _____	Hepatitis _____
Cancer _____	Hearing/Ear Disorder_____	Psychiatric Disorder_____	Tetanus _____
Epilepsy _____	Unexplained Weight Loss___	GI Disorder _____	Measles _____
Ulcer _____	Depression _____	Allergies/Hay fever _____	Bronchitis _____

HAVE YOU EVER HAD SURGERY OR BEEN HOSPITALIZED FOR 24 HOURS? **YES / NO** (PLEASE CIRCLE)

LIST SURGERY/HOSPITALAZATION:	**ON DATE:**	**COMPLICATIONS:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS:

Do you smoke now?_____
How long? _____
Packs/day _____
Are you interested in stopping?_____
Have you ever smoked?_____
If yes, how long since you quit?_____

(PLEASE CIRCLE BELOW WHICH APPLY)

Alcoholic beverages?	Recreational Drugs?	Caffeine Use:_____
None	None	None
Rarely	Rarely	Rarely
Moderately	Moderately	Moderately
Daily	Daily	Daily
Quit	Quit	Quit

Special Diet:_____
_____
Exercise Routine:_____
_____
Sleep Disorder:_____
_____