Adult Medical History

Date: ____________________ Referred by: ____________________

Name: ____________________ Sex: M or F Marital Status: ____________________

Birthdate: ____________________ Occupation: ____________________

Please list any current medical problems or concerns:

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Past Medical Illnesses:

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Previous Surgeries or Hospitalizations:

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Medications:

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Allergies:

____

Personal History	Yes	No	How Much
Do you smoke?	____	____	____________________
Do you drink alcohol?	____	____	____________________
Do you use illegal drugs?	____	____	____________________
Do you consume caffeine? (ex: coffee, tea, pop)	____	____	____________________

Family History- Please check any condition present in your blood relatives and then list how they are related to you.

		List the family member
Cancer	____	____________________
Diabetes	____	____________________
High Blood Pressure	____	____________________
Heart Disease	____	____________________
Stroke	____	____________________
Asthma	____	____________________
Thyroid Disease	____	____________________
Other: ______________	____	____________________

PLEASE TURN OVER PAGE AND COMPLETE !