Medical History

NAME:_____ DATE:_____ DATE of BIRTH_____ AGE:____

HEIGHT: _____ WEIGHT: _____ BMI:_____

ALLERGIC TO: _____
(Include meds that cause nausea, rash, diarrhea)

Prescription Drugs:	Dosage:

Do you use aspirin or ibuprofen (Advil) or Naproxyn (Aleve)?
____ Yes ____ No

Herbal Medications / Including Vitamins

	YES	NO	AMOUNT PER DAY
SMOKING	_____	_____	_____
ALCOHOL	_____	_____	_____

SAFETY BELT USE (circle one) ALWAYS OCCASIONALLY NEVER

FAMILY SOCIAL HISTORY

Your Mother's Age ____ Your Mother's Health _____

Your Father's Age ____ Your Father's Health _____

Your Children's Ages: _____

EDUCATION

Years Completed: _____ Degree(s) _____

EMPLOYMENT

Occupation: _____

Years at Present Occupation: _____

LIST ALL PREVIOUS SURGERIES

DATE	TYPE	SURGEON

LIST ALL PREVIOUS INJURIES/FRACTURES

DATE	BODY PART	WORK LOSS?

How many times have you fallen in the last two years? _____

EXERCISE REGULARLY? YES NO (circle one)

If yes, describe your exercise program:

_____

_____

HOBBIES: _____

_____

_____
Date