MEDICAL HISTORY

PERSONAL HISTORY: Date: - -

Name: Birth date: - -

Home Phone: ( ) Work Phone: ( )

Occupation: Hours/Week: Shift Work: Y N

How long have you performed this type of work: Education Level:

If applicable, college degree(s), year and field:

Marital Status: S M W D Cohabitating Spouse or significant other's name:

Number of children: List the year(s) of their birth(s):

Recreation or Hobbies:

Exercise (Frequency and Duration):

Sleep: hrs/night Quality: Poor Fair Good Excellent

Do you take sleeping aids: Y N Type:

HABITS:

Average amount per day or week of the following: (of if quit, when):

No Yes Quit Caffeine (type):

No Yes Quit Recreational Drugs:

If yes, any IV use in the past: No Yes

No Yes Quit Alcohol (type):

No Yes Quit Tobacco (type):

Age started using tobacco:

PAST MEDICAL HISTORY:

Have you ever had:

			Year				Year
Anemia	Yes	No		Hepatitis (yellow jaundice)	Yes	No	
Arthritis	Yes	No			Yes	No	
Asthma	Yes	No		High Blood Pressure	Yes	No	
Bladder infection	Yes	No		Hives	Yes	No	
Bleeding Tendency	Yes	No		Infectious Mono	Yes	No	
Blood Transfusion	Yes	No		Kidney Disease	Yes	No	
Bronchitis	Yes	No		Malaria	Yes	No	
Cancer	Yes	No		Meningitis	Yes	No	
Chronic Diarrhea	Yes	No		Mental Illness	Yes	No	
Chronic Lung Disease	Yes	No		Nose Bleeds	Yes	No	
Depression	Yes	No		Obesity	Yes	No	
Emphysema	Yes	No		Pneumonia	Yes	No	
Epilepsy	Yes	No		Polio	Yes	No	
Hay Fever	Yes	No		Repeated Infections	Yes	No	
Heart Disease	Yes	No		Seizures	Yes	No	
Headaches	Yes	No		Sinusitis, Chronic	Yes	No	
Hemorrhoids	Yes	No		TB or exposure to	Yes	No	

Other, If so please specify:

HOSPITALIZATIONS: Reason and year

Medication List: