

Please check if you have an allergy to: Eggs Iodine Shellfish

Please list any food allergies: _____

FAMILY HISTORY

Do you have a family history of:

	No	Yes	Family Member		No	Yes	Family Member
Anesthesia problems				High Blood Pressure			
Bleeding problems				Osteoporosis			
Cancer (location)				Stroke			
Diabetes				Thyroid Disease			
Heart disease				Other Disease			

SOCIAL HISTORY

Occupation: _____ Retired Disabled Unemployed

Marital Status: Single Married Separated Divorced Widowed

Number of children: _____ Hobbies: _____

Your personal habits: Do you.....

	No	Yes		No	Yes
Regularly exercise (3-4 times a week)			Use alcohol		
Wear auto seat belts (90% of the time)			Smoke (if ever, when did you stop? _____)		
Use illegal drugs					

Are you right handed left handed

Are you an athlete? No Yes - What sport(s)? _____
 Level: Recreational Middle school High school College

REVIEW OF YOUR BODY SYSTEMS: Do you have now or have you had any of the following within the past year?

	No	Yes	Present now	In past year
Unexplained fever				
Unexplained weight loss				
Recent weight gain				
Fatigue				
Vision changes				
Hearing problems				
Neck pain				
Neck swelling				
Shortness of breath				
Coughing blood				
Chest pain				
Irregular heart beat				
Stomach pain				
Heartburn				
Diarrhea				
Constipation				
Stool changes				
Urinary frequency/burning				
Blood in urine				
Swollen or painful joints				
Blackouts or seizures				
Anxiety				
Depression				
Yellow skin				
Skin lesions or ulcers				