Please list any allergies or intolerance to drugs or other substances.___________________________

Please list the medications currently taken, their dosages, and how many times per day you take them.

Family Medical History

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Hemophilia
- ☐ _______________
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Neurological Disorder
- ☐ Liver Disease
- ☐ ________________
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ ________________

Notes: ____

Personal Information

Please write in or circle the information that applies to you:

Occupation:

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternate Medicine
Primary	Heterosexual	Single	Alone	None	None	Holistic
Secondary	Homosexual	Married	With Spouse	Low Fat	Walking	Chiropractic
College	Bisexual	Divorced	With Parents	Low Chol	Aerobics	Homeopathy
post grad	Transsexual	Widowed	Assisted Living	Low Carbo	Weightlifting	Acupuncture
doctorate		Separated	Nursing Home	Vegetarian	__days/wk	Herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
never / past / active	never / past / active	Never / Pas t/ Active	Never / Past / Active
Cigarette /Cigar / Pipe	Liquor / Wine / Beer	Cocaine / Marijuana	Coffee / tea / soda
Snuff / dip / chewing	___ drinks per	Heroin / Amphetamine	__ cans / cups per day
Start____	Day / Week / month	barbiturate / LSD / PCP	
Stop____	AA / Alcohol Rehab	IV Drug Abuse / Drug Rehab	
Packs per day____			

Doctor's Notes: ____