Integrated

MEDICAL HISTORY FORM

Name: _____ Date: _____ Age: _____

Please indicate if you have a history of the following medical problems:

Diabetes (Sugar)	Yes( ] No [	Heart Disease	Yes[No [	Kidney/Bladder	Yes[ ] No [ ]
Arthritis	Yes[ ] No [	Seizures/Epilepsy	Yes[No [	Cancer	Yes[ ] No [ ]
High Blood Pressure	Yes( ] No [	Colon/Ulcer	Yes[No [	Lung Disease	Yes[ ] No [ ]
Any other conditions not listed?					

Please List Past Surgeries: _____

_____

Please List Current Medications: _____

_____

Are you allergic to any medications? Yes [ ] No [ ]. If yes, please list:

If you are a female, are you pregnant? Yes [ ] No [ ]

Please indicate if you have any Family Members with history of the following medical problems:

Diabetes (Sugar)	Yes[ ] No [ ]	Heart Disease	Yes[ ] No [ ]	Kidney/Bladder	Yes[ ] No [ ]
Arthritis	Yes[ ] No [ ]	Seizures/Epilepsy	Yes[ ] No [ ]	Cancer	Yes[ ] No [ ]
High Blood Pressure	Yes[ ] No [ ]	Colon/Ulcer	Yes[ ] No [ ]	Lung Disease	Yes[ ] No [ ]
Any other conditions not listed?					

Do you smoke? Yes [ ] No [ ] Do you use any recreational drugs? Yes [ ] No [ ]
Are you employed? Yes [ ] No [ ] Are you disabled? Yes[ ] No [ ]

Signature _____ Date _____