MEDICAL HISTORY

List any and all current medication with doses, including nutritional supplements. (Please use back if needed.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all childhood illnesses. **Were you vaccinated? Yes or No**

_____ _____

_____ _____

List all adult illnesses.

_____ _____

_____ _____

List all known allergies. **Do you carry an epi-pen? Yes or No**

_____ _____

_____ _____

List all surgeries and the date.

_____ _____

_____ _____

List all injuries and the date.

_____ _____

_____ _____

Social History: Often = O Sometimes = S Never = N

_____ Exercise _____ Alcohol Use _____ Caffeine _____ Drug Use

_____ High Stress Activity _____ Tobacco Use _____Mental Stresses _____ Family Pressures