



### FAMILY HISTORY

	SELF	FATHER	MOTHER	SIBLING		SELF	FATHER	MOTHER	SIBLING
AGE (IF LIVING)					EPILEPSY				
HEALTH (G) GOOD (B) BAD					NERVOUSNESS				
CANCER					ASTHMA, HIVES, HAYFEVER				
DIABETES					BLOOD DISEASE				
HEART TROUBLE					AGE (AT DEATH)				
GOUT					CAUSE OF DEATH				
STROKE									

### PERSONAL HISTORY

HAVE YOU EVER HAD . . .	YES	NO	HAVE YOU EVER HAD . . .	YES	NO	HAVE YOU EVER HAD . . .	YES	NO
SCARLET FEVER			ANEMIA			ANY <input type="checkbox"/> BROKEN <input type="checkbox"/> CRACKED BONES		
PNEUMONIA			VARICOUS VEINS			RECURRENT DISLOCATIONS		
RHEUMATIC FEVER			KIDNEY DISEASE			SPRAINS		
<input type="checkbox"/> ARTHRITIS <input type="checkbox"/> RHEUMATISM			MIGRAINE HEADACHES			ARE YOU CURRENTLY PREGNANT?		
ANY <input type="checkbox"/> BONE <input type="checkbox"/> JOINT DISEASE			TUBERCULOSIS			CURRENTLY NURSING		
<input type="checkbox"/> NEURITIS <input type="checkbox"/> NEURALGIA			STOMACH TROUBLE					
<input type="checkbox"/> BURSTITIS <input type="checkbox"/> SCIATICA <input type="checkbox"/> LUMBAGO			ULCERS			HAVE TESTED HIV POSITIVE		
<input type="checkbox"/> POLIO <input type="checkbox"/> MENINGITIS			LIVER DISEASE			EXPLAIN:		
LOWER BACK PAIN			LEG CRAMPS					
GLAUCOMA			ECZEMA					
VASCULAR DISEASE			THYROID DISEASE					

### ALLERGIES

**LIST ANY CURRENT ALLERGIES:**


### SURGERY

HAVE YOU HAD . . .	YES	NO	HAVE YOU . . .	YES	NO	HAVE YOU . . .	YES	NO
FOOT/ANKLE SURGERY			BEEN HOSPITALIZED FOR ANY ILLNESS			HAD ANY RECENT OPERATIONS		
EXPLAIN:			EXPLAIN:			EXPLAIN:		

### HABITS

DO YOU USE . . .	NEVER	OCC.	FREQ.	DAILY	DO YOU . . .	YES	NO
ALCOHOLIC BEVERAGE					PARTICIPATE IN SPORTS		
CAFFEINE					<b>HAVE YOU EVER . . .</b>	<b>YES</b>	<b>NO</b>
TOBACCO: <input type="checkbox"/> CIGARETTES ( PKGS PER DAY)					BEEN TREATED FOR ALCOHOLISM		
<input type="checkbox"/> CIGARS <input type="checkbox"/> PIPE <input type="checkbox"/> CHEWNG TOBACCO					BEEN TREATED FOR DRUG ABUSE		

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Thank you for choosing our office.*