



# Medical History

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Have you had a problem with any of the following now or in the past, briefly describe:

- Vaginal \_\_\_\_\_
- Bladder \_\_\_\_\_
- Bowel \_\_\_\_\_
- Breast \_\_\_\_\_
- Skin \_\_\_\_\_
- Eyes \_\_\_\_\_
- Ears \_\_\_\_\_
- Nose \_\_\_\_\_
- Throat \_\_\_\_\_
- Neck \_\_\_\_\_
- Lungs \_\_\_\_\_
- Heart \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Legs/Arms \_\_\_\_\_
- Muscular \_\_\_\_\_
- Nerves \_\_\_\_\_
- Emotions \_\_\_\_\_

List any surgery you have had done and the dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or anyone in your family have a history of --- (if so, list family members)

- Heart Disease \_\_\_\_\_
- Diabetes \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Cancer \_\_\_\_\_
- Thyroid Problems \_\_\_\_\_
- Anemia \_\_\_\_\_
- Seizures/Strokes \_\_\_\_\_
- Births Defects \_\_\_\_\_
- Genetic Disorder \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Severe Arthritis \_\_\_\_\_
- Other \_\_\_\_\_

### Social History:

Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Do you work? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, type of work? \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any history of substance abuse? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been immunized against any diseases? Yes \_\_\_\_\_ No \_\_\_\_\_