YOUR PAST HISTORY

✔	Past Problem	When and Explain
	Cancer	
	Stroke	
	Thyroid Problems	
	Asthma	
	Heart Attack	
	HIV/AIDS	
	Angina/Chest Pain	
	Diabetes	
	Gout	
	Broken Bones/Fractures	
	Depression	
	Other	

List all surgeries and year:_____

List all Injuries and year:_____

List all medications:_____

SOCIAL HISTORY

Circle all that apply

Do you exercise? Regularly Frequently Occasionally Never At what level? Competitively High Medium Low

Sufficient Rest? Always Mostly Sometimes Never Hours of Sleep?_____

Do you Smoke? Yes No Packs Per Day:_____ Do You Drink Alcohol? Yes No Drinks Per Day:_____

Hobbies:_____

FAMILY HISTORY

If anyone in your immediate family has had any of these diseases, please check those that apply.	Grand-mother (Dad)	Grand-father (Dad)	Grand-mother (Mom)	Grand-father (Mom)	Father	Mother	Siblings
Cancer							
Heart Disease							
High Blood Pressure							
Stroke							
Diabetes							
Epilepsy							
Mental Illness							
Other (explain)							
Who is still living?							

Signature: _____ **Date:** _____