PAST MEDICAL HISTORY. List illnesses and conditions you have had and the year.	
1.	4.
2.	5.
3.	6.

MEDICATIONS: List medications you are currently taking including OTC and Supplements.		ALLERGIES: To medications or substances
1.	9.	
2.	10.	
3.	11.	
4.	12.	
5.	13.	
6.	14.	
7.	15.	
8.	16.	

SURGICAL HISTORY:		
Type of Surgery	Year	Complications if any

SOCIAL HISTORY: Check the substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Alcohol	
	Exercise	

FAMILY HISTORY: List any illnesses that run in your family:	
1.	5.
2.	6.
3	7.
4.	8.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature:____ Date: ________________