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MEDICAL HISTORY

NAME _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

ALLERGIES _____

ALCOHOL _____ SMOKING _____

FAMILY HISTORY:

DIABETES _____

CANCER _____

HEART DISEASE _____

ELEVATED CHOLESTEROL _____

ELEVATED BLOOD PRESSURE _____

GENETIC DISORDERS _____

OSTEOPOROSIS _____

THYROID DISORDER _____

OTHER _____

PATIENT'S HISTORY (Include hospitalizations, surgeries, pregnancies and deliveries with approximate dates.)

Signature _____

Date _____