

MEDICAL HISTORY

Are you allergic to any medications (drugs) ? YES NO If yes, please list. _____

Are you currently taking any prescription or non-prescription medications? YES NO If so, please list. _____

Have you ever been hospitalized for anything other than childbirth? YES NO If so, please describe. _____

Have you ever had any type of surgery? YES NO If so, please describe. _____

PLEASE CHECK IF YOU HAVE HAD A HISTORY OF ANY OF THE FOLLOWING

	YES	NO		YES	NO
Are you currently pregnant?			Asthma		
High blood pressure			Phlebitis		
Rheumatic fever			Arthritis		
Limb numbness, tingling, swelling, or burning			Anemia		
Circulatory problems			HIV / AIDS		
Skin problems/disorders			Heart disease		
Tetanus Immunization			Diabetes (sugar)		
STD-sexually transmitted diseases such as gonorrhea or chlamydia					

Other illnesses or diseases which are not listed? Please describe _____

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Arthritis		
Kidney disease			Bunions		
Abnormal bleeding tendencies			Heart disease		
Lung disease					

SOCIAL HISTORY

What is your approximate weight? _____ | Height? _____ ft. _____ in. | Shoe size _____

What is your current occupation? _____

How many hours per day do you stand? _____

Do you smoke cigarettes? YES NO If yes, how many packs per day? _____

Do you drink alcohol? YES NO If yes, how many drinks per week? _____

Do you use Marijuana? YES NO _____

Do you use Cocaine? YES NO _____

Please present a copy of your primary and secondary (if applicable) insurance card to the receptionist.
Please present your driver's license to the receptionist.