HISTORY SHEET

Please answer all questions as completely to the best of your knowledge. If you answer "YES" to any of the questions, please explain with as much detail as possible. Please print clearly.

Name: _____ Age: _____

Please Circle One: Married, Single, Divorced, Separated, Widow (er). Right or Left Handed? _____

Please state the number of the children you have: _____ What is your height? _____ Weight? _____

Do you smoke tobacco? [Yes / No]—Do you drink alcohol? [Yes / No]--- If yes, how much daily? _____

Past Medical History: Please list in the space below any health problems you may have such as diabetes, cancer, arthritis, heart disease, high blood pressure, etc., _____

_____

Do you have a family physician? Yes / No ----- [Physician's name and location.] _____

_____ How long have you been under this physician's care? _____

Are you allergic to any medication? Yes / No ----- [Name(s):] _____

_____

Are you taking any type of medications at this time? Yes / No ----- [Name(s) and Dosage:] _____

_____

Have you had any operations in lifetime? Yes / No ----- If yes, please list the date(s), hospital(s) and type of procedure(s):

_____

_____

Have you ever been admitted to the hospital? Yes / No ----- If yes, please list the date(s), hospital(s) and reason? _____

_____

_____

Have you ever had any broken, fractured or dislocated bones? Yes / No ----- [Body parts affected:] _____

_____

Have you ever been involved in any **litigated** claims of bodily injury, including but not limited to, automobile accidents, slip and falls, etc.? Yes / No ----- [Accident details:] _____

_____

_____

Have you ever been involved in any **non-litigated** claims of bodily injury, including but not limited to, automobile accidents, slip and falls, etc.? Yes / No ----- [Accident details]: _____

_____

_____

Do you have a family history of the following? (Please circle and state family member affected for any that apply)

Diabetes _____ Heart Disease _____ Tuberculosis (TB) _____

Cancer _____ High Blood Pressure _____ Arthritis _____

I have read all of the information on this sheet and have completed all of the answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature Print Name Date

_____ _____

Interpreter Signature Print Name and Lic. # Date