PERSONAL PAST MEDICAL HISTORY FORM

Name: ______________________________ Age: __________ Date: __________

Occupation: ______________________________ Marital Status: S – M – W – D (Circle One)

Current Medications: ______________________________

____

Drug Allergies: ______________________________

Do you have or have you had: Check ALL that apply

___ High Blood Pressure	___ Asthma / COPD	___ Cancer	___ Thyroid Disease	___ Blood Transfusion
___ High Cholesterol	___ Pneumonia	___ Epilepsy	___ Kidney Problems	___ Hepatitis
___ Heart Attack / CHF	___ Stomach Ulcers	___ Headaches	___ Gout	___ Tuberculosis
___ Stroke	___ Colitis	___ Psoriasis	___ Cataracts	___ Deep Vein Thromb
___ Diabetes	___ Anemia	___ Liver Problems	___ Glaucoma	___ Pulm Embolus

*Other Significant Illness: ______________________________

Hospitalizations & Surgeries: Year

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

Cigarettes / Day _______ x _____ years Alcohol (oz) / Week ___________ Exercise / Week ___________ Highest Level of Education:

*QUIT ___________ *DRY ___________ (Minutes) HS / College / Professional

Fractures: Part of Body Age @ Time of Fracture How fracture occurred

L / R ______________________________

L / R ______________________________

Previous Bone Density: ______________________________

Age at Menopause: __________ Family Members with Osteoporosis: ______________________________

Family History: Current Age Health Problems Age & Cause of Death

Father: ______________________________

Mother: ______________________________

___ Siblings: _____ Brothers & _____ Sisters: ______________________________

___ Children: _____ Boys & ____ Girls: ______________________________

____

*<u>**Family Contact**</u>: ______________________________