NAME : _____ DATE : _____

GENERAL HEALTH (CIRCLE ONE) GOOD FAIR POOR

YES _____ NO _____ HAVE YOU EVER BEEN SERIOUSLY ILL ?

YES _____ NO _____ HAVE YOU EVER BEEN HOSPITALIZED ?

YES _____ NO _____ HAVE YOU HAD SURGERY ? WHEN _____

WHAT KIND ? _____

YES _____ NO _____ ARE YOU PREGNANT?

HAVE YOU EVER HAD :

YES _____ NO _____ CANCER

YES _____ NO _____ HEART TROUBLE

YES _____ NO _____ DIFFICULTY WITH BREATHING

YES _____ NO _____ LUNG DISEASE (FOR INSTANCE : PNEUMONIA, ASTHMA OR EMPHYSEMA)

YES _____ NO _____ JAUNDICE, HEPATITIS

YES _____ NO _____ DIABETES

YES _____ NO _____ FAINTING SPELLS

YES _____ NO _____ ALLERGIES TO MEDICATIONS (IF YES, WHAT MEDICATIONS AND WHAT TYPE OF REACTION; RASH, SWELLING, etc.)_____

_____

YES _____ NO _____ RHEUMATIC FEVER

YES _____ NO _____ HIGH BLOOD PRESSURE

YES _____ NO _____ ANEMIA OR BLEEDING PROBLEMS

YES _____ NO _____ OTHER SERIOUS PROBLEMS : WHAT _____

YES _____ NO _____ STOMACH ULCERS

YES _____ NO _____ TAKE MEDICATION REGULARLY (INCLUDING BIRTH CONTROL PILLS)

WHAT KIND _____

_____

_____

YES _____ NO _____ SMOKE _____ PKG / DAY

YES _____ NO _____ DRINK ALCOHOL (IF SO, DO YOU HAVE IT DAILY, SOCIALLY; OCCASIONALLY, RARELY) _____

HAVE YOU EVER HAD :

YES _____ NO _____ BROKEN BONES (IF SO, WHICH ONES AND WHEN) _____

_____

YES _____ NO _____ HEAD INJURIES : WHEN _____

YES _____ NO _____ NECK INJURIES : WHEN _____

YES _____ NO _____ BACK INJURIES : WHEN _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EVER HAD :

YES _____ NO _____ CANCER YES _____ NO _____ LUNG DISEASES, TB, etc.

YES _____ NO _____ HEART DISEASE YES _____ NO _____ DIABETES

HT : _____ WT: _____ RIGHT / LEFT HANDED _____