HEALTH HISTORY (Continued)

FAMILY History (Please check any that apply)

☐ Headaches/migraines	☐ Multiple sclerosis	☐ Diabetes	☐ Thyroid
☐ Stroke	☐ Nerve/muscle disease	☐ Heart disease	☐ Alcoholism/addiction
☐ Aneurysms	☐ Dementia	☐ Cancer:_____	☐ Glaucoma
☐ Seizures/Epilepsy	☐ High blood pressure	☐ Arthritis	☐ Other:_____

Medications / Dosage

Allergies (medication, foods, latex, etc.)

Hospitalizations / Surgeries (Please include dates)

Social History

Tobacco User? O Yes O No O Quit (when?)_____ If yes, how many packs per day?_____

Alcohol (beer/wine/liquor)? O Yes O No O Quit (when?)_____ If yes, how many drinks per day?_____

Drug Use? O Yes O No O Quit (when?)_____

Caffeinated Beverages? O Yes O No_____ If yes, how many cups/cans per day?_____

Occupation:_____

Please List Other Symptoms

Please List Any Questions for the Doctor