MEDICAL HISTORY INFORMATION

Date…….....

Name……

Presenting symptoms……

……..

……..

List of past illnesses…….

……..

……..

Current medications you are taking……..

……..

Do you have any allergies?.....

Do you smoke?...Yes/No...If yes, how many cigarettes per day?.....

If No, have you quite smoking?...Yes/No…When did you quit?.....cigarettes per day?.....

Do you drink alcohol?...Yes/No...If Yes, how many drinks per day?.....

What is/was your occupation?.....

Are you right or left handed?.....

Who lives with you at home?.....

Do you have any family history of medical illness?.....

Do you drive?.....