

Name: _____ DOB: _____ Date: _____

CURRENT OR PAST MEDICAL CONDITIONS

Has **anything changed** since your last visit? Otherwise, leave blank.

MEDICATIONS

Has **anything changed** since your last visit? Otherwise, leave blank.

MEDICINE ALLERGIES

Has **anything changed** since your last visit? Otherwise, leave blank.

HEALTH RELATED HABITS

Has **anything changed** since your last visit? Otherwise, leave blank.
(Tobacco, alcohol, or drug use; exercise or activities; etc.)

FAMILY HEALTH HISTORY

Has **anything changed** since your last visit? Otherwise, leave blank.

Has any of the following information changed? If so, please make the appropriate corrections. Otherwise, leave blank.

Address:		City:	State/Zip:
Highest/Current Education Level :	Current/Last Occupation:	Employer/School:	
Job physical activity requirements:		<i>If Disabled, list reason:</i>	
Current/Recent Sports or Physical Activity:			
Spouse's name (Adults):		If none, are you:	Single Divorced Widowed
Best Daytime Contact #	Best Evening Contact #	Cell Phone #	
Best Contact Email Address:			
Primary Care Physician:		Referring Physician:	