Name_____ Date_____

Prescription Medication	Dosage
Non Prescription such as Vitamins/Herbal supplements	

Allergies to medications or environment? YES NO
Please list and explain the reaction: _____

Smoking History:
____ Never smoked
____ 0 but was a previous smoker
____ Few 1-3 cigarettes per day
____ Up to a pack a day
____ 2 or more packs per day

Height	Weight	Blood Pressure

What is your occupation? _____ Work activity posture._____

Hobbies/Repetitive Activities_____

Fractures or serious accidents?_____

Any additional information that you would like the doctor to know?_____

_____
_____