

◆ **MEDICAL** (Write "None" for any questions that do not apply)

How is your overall health now? Excellent Good Fair Poor

What physical or mental problems do you now have? _____

Are you currently under a doctor's care? Yes No Why? _____

When was your last physical exam? _____

What prescription medications are you now taking? _____

What over-the-counter products (aspirin, cough medicine, etc.) are you now using? _____

Have you or anyone in your family ever had or been diagnosed as having any of the following?

(Check NONE for questions that do not apply)

You	Family	None		You	Family	None	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning nausea, vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Fingers or Toes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic or anxiety attacks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delirium Tremens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatty Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shaking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastro esophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant weight loss or gain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache or Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or gastritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Antabuse or Trexan
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Prescription Drugs

How many times in the past five years have you been hospitalized? _____ When? _____
Reason? _____

How many times in the past five years have you used Emergency Room Services? _____ When? _____
Reason? _____

How many days in the past five years have you used sick leave (all employers)? _____ When? _____
Reason? _____

Have You Ever:	Yes	No	Alcohol or Drug related:	Please explain:
Had any fractures or dislocations to your bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been injured in a traffic accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injured your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been injured in an assault or fight (not sports injuries)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been injured while drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____