PERSONAL HEALTH HISTORY

Birth Date ___/____/_____  Age _____  Sex ___  Height _____  Weight _____

Please circle your answer.

1. Do you smoke any tobacco products?
   
   yes   no

2. Have you ever had any kind of surgery or operation?
   
   yes   no

   If yes, what type of surgery: ____________________________________________
   ____________________________________________
   ____________________________________________

3. Have you ever been in the hospital for any other reasons?
   
   yes   no

   If yes, please describe the reason: _______________________________________
   _______________________________________
   _______________________________________

4. Do you have any on-going or current medical problems or conditions?
   
   yes   no

   If yes, please describe: ________________________________________________
   ______________________________________________
   ______________________________________________