CRESTWOOD WORKERS CARE

7736 Madison Blvd • Huntsville, AL 35806
256-830-8930 • *fax* 256-830-8932

Medical History

Name:	□ Male □ Female	Date of Birth:	Social Security Number:
Home Address:			Phone:
Company/Location:		Dept:	Job Title:

Have you **had** or do you **now have** any of the following conditions? Mark "Yes" or "No". Indicate age when the condition occurred.

	Yes	No	Age		Yes	No	Age		Yes	No	Age
Allergies, hay fever, drug interaction				Eye trouble, injury, blindness				Other autoimmune disorder(s)			
Ankle weakness				Fibromyalgia or STDS				Paralysis			
Asthma				Foot trouble				Polio			
Anemia or blood disease				Headaches, frequent or severe				Rectal disease, blood in stool, hemorrhoids			
Back Trouble				Hearing loss				Rheumatic fever			
Bone or joint deformity				Heart trouble				Rheumatism or arthritis			
Bowel trouble				Hepatitis or liver disease				Shoulder, painful or "trick"			
Broken bone(s)				Hernia				Sinus trouble			
Cancer or tumor				High blood pressure				Skin disease			
Chest pain or pressure				HIV or other immunological disorder(s)				Thyroid disease			
Chronic cough				Hives				Tuberculosis			
Diabetes				Kidney stone or blood in urine				Ulcers			
Dizziness/fainting spells, head injury or loss of consciousness				Knee, painful or "trick" or "locked"				Varicose Veins			
Elbow, painful or "trick"				Nervous breakdown				Other			
Epilepsy or seizures				Memory Loss							

Family Medical History - List medical conditions of the following family members:

Mother:	Father:
Sisters:	Brothers:

Yes	No	History
		Have you ever been hospitalized? Date(s): Reason:
		Have you ever had surgery? Date(s): Type of Surgery:
		Have you had any major illnesses in the past five (5) years? Date(s): Condition:
		Do you have any allergies? Medications / reaction caused: Food:
		Are you currently taking any medications either prescribed or over the counter (include birth control pills or herbs)? List medication(s):

Yes	No	Personal Habits
		Do you now or have you ever smoked or used tobacco products? Type: Amount per day: # of Years:
		Do you presently consume alcoholic beverages? Type: Amount per day: # of Years:
		Do you exercise regularly? Type: Amount per day: # of Years:

Medical History continued…