HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROCEDURES PERFORMED?

	DATE	PLACE	RESULT			
LAST CHEST X-RAY						
LAST SINUS X-RAYS						
LAST PULMONARY FUNCTION						
LAST EKG						
LAST BLOOD CHEMISTRIES						

FAMILY HISTORY (MEDICAL AND ALLERGIC)
PLEASE PLACE AN 'X' IN THE APPROPRIATE BOX

	ASTHMA	NASAL	ECZEMA	HIVES	DRUG ALLERGY	FOOD ALLERGY	ANAPHY LAXIS	MEDICAL PROBLEM NAME
MOTHER								
FATHER								
SISTER								
SISTER								
BROTHER								
BROTHER								
CHILD								
CHILD								
CHILD								
CHILD								
RELATIVE								

DO YOU SMOKE OR HAVE YOU SMOKED IN THE PAST?								
PLEASE CHECK WHAT?			CIGAR		CIGARETTE		PIPE	
WHEN DID YOU START?			DATE					
WHEN DID YOU STOP?			DATE					
HOW MANY PER DAY?								
WHAT IS YOUR AVERAGE ALCOHOL INTAKE?					BEER		WINE	
	SPIRITS		DAILY		WEEKLY			