Medical History - continued

SELECT AN ANSWER			IF YES, PLEASE EXPLAIN
		YOUR BIRTH	
No	Yes	Forceps, C-Section, Breach / cephalic?	
		CHILDHOOD	
No	Yes	Major childhood illnesses?	
No	Yes	Accidents or physical trauma?	
No	Yes	Chronic ear infections?	
No	Yes	Sore Throats?	
No	Yes	Bed Wetting?	
No	Yes	Mental / Physical Abuse?	
		RECENT	
No	Yes	Did / do you smoke / vape?	
No	Yes	Did / do you drink any alcohol? How Often?	
No	Yes	Diet: Do you eat healthy foods?	
No	Yes	Do you use drugs? (Prescriptive or non-prescriptive)	
No	Yes	Exercise regularly?	
No	Yes	Did / do you have occupational stress?	

Back

Next