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*Name*

**Have you ever had surgery? YES/NO**

**An overnight stay in the Hospital? YES/NO**

**Surgeries/Hospital Stays:** [please provide dates if possible]

**Have you ever had any injury/fracture? YES/NO**

**Injuries/Fractures:**

[please provide location/date/duration of treatment]

**Family Medical History:**

[mother, father, brothers, sisters, aunts, uncles, grandparents]

[diabetes, heart disease, high blood pressure, cancer, arthritis, depression, liver disease, gout, CMT, etc]