

## CURRENT HEALTH CONDITION

Is there any chance that you could be pregnant? Yes / No / Not Applicable (male)

Have you ever been treated for the abuse of prescribed medication, drugs, or alcohol?

Yes / No

If yes please specify \_\_\_\_\_

Have you ever had an allergic reaction to any medication, dye, bee stings, bug bites, or shellfish?

Yes / No

Please List: \_\_\_\_\_

\_\_\_\_\_

Do you drink alcohol? Yes / No Drinks per day: \_\_\_\_\_

Do you smoke?

- Cigarettes (Packs/Day) \_\_\_\_\_
- Cigars (# Per Day) \_\_\_\_\_
- Pipe

Are you working?  Yes  No If Yes:  Full time  Part time  Restricted duty

What is your occupation? \_\_\_\_\_

If no, date last worked: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

What activities of daily living are you not able or have difficulty performing :

- Housekeeping  Childcare  Yard work  Cooking
- Errands(grocery, dry cleaners, etc)  Getting out out bed/showering/dressing
- Daily hygiene  Driving

What activities/sports/hobbies do you enjoy? \_\_\_\_\_

\_\_\_\_\_

Is your pain restricting your activities/sports/hobbies?  Yes  No

If yes, how? \_\_\_\_\_

\_\_\_\_\_

