

BRIEF MEDICAL HISTORY:

Family Doctors Name, Address, Telephone Number:			
Please list any and all medication below:			
Name of Medication	Prescribed By:	Reason Prescribed:	When was it started?
Do you have any allergies? If so what?			
Is an Epi-Pen required for the above allergy?			
Do you have any of the following (Indicate Yes with a check mark)			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowel Problems	
<input type="checkbox"/> Ear/hearing Problems	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Stomach Problems	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Hernia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Convulsions/seizures	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pregnancy	
Are there any major health concerns that you have that are not listed above?			

LEGAL HISTORY:

Are you currently on probation? If so, for how long and what are the conditions?
Are you on parole? If so, for how long and what are the conditions?
Do you have to attend court? If so, when and for what?
Do you belong to or were you associated with a gang?
Please indicate if you have had any of the past offenses listed below? Check all that apply

<input type="checkbox"/> Theft/Possession Property	<input type="checkbox"/> Probation/Parole Violation	<input type="checkbox"/> Willful damage/mischief	<input type="checkbox"/> Murder/Manslaughter
<input type="checkbox"/> Drug Charges	<input type="checkbox"/> Weapons Offenses	<input type="checkbox"/> Robbery	<input type="checkbox"/> Assault
<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Burglary/B&E	<input type="checkbox"/> Forgery	<input type="checkbox"/> Arson
<input type="checkbox"/> Impaired Driving	<input type="checkbox"/> Prostitution	<input type="checkbox"/> Sexual Abuse to a child	<input type="checkbox"/> Other

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