CMH Auxillary Health Questionnaire

Name

Address

Social Security # Birthday

List the physicians you see on a regular basis, including phone numbers:

Physician

Phone Number

Physician

Phone Number

Physician

Phone Number

List all of the surgeries you have had in the past 10 years:

Check the following questions yes or no.
Have you had or do you currently have?:

	Yes	No
Addictions	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Cancer	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Visual Problems	☐	☐
Hearing Loss	☐	☐
Heart Problems	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Low Blood Sugar	☐	☐
Migraine Headaches	☐	☐
Medical Disability	☐	☐
Stroke	☐	☐

List all of the medications you are currently taking:

The above information is true and complete to the best of my knowledge. I understand that any misrepresentation and/or omission is grounds for immediate discharge.

Signature Date

Submit by Email Print Form