AA - Fort Eustis VA

Medical Information Form

Medical Questionnaire	
Medical Questionnaire	
Family Physician	_____
Phone	_____
Are you currently under care of a Physician ?	☐
If Yes, What is the condition being treated ?	_____
Have you had any Serious Illness, Operation or been Hospitalized within the past 5 years ?	☐
If Yes, what illness or Problem	_____
Are you currently taking any Medication ?	☐
If Yes What ?	_____
Have you ever taken the Diet Control Drug Fen-Phen ?	☐
Do you use Alcoholic Beverages ?	☐
Do you Smoke ?	☐

Women Only

Are you Pregnant? ☐

If Yes, what is your Due Date ? _____

Are you Currently Nursing ? ☐

Do you have Menstrual Period Problems ? ☐

Are you on Hormone Replacement Therapy ? ☐

Are you on Birth Control Pills/Fertility Drugs ? ☐

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Anemia ☐