

FAMILY HISTORY - Fill in health information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following and indicate relationship to you:
Father	_____	_____	_____	_____	<input type="checkbox"/> Arthritis, Gout _____
Mother	_____	_____	_____	_____	<input type="checkbox"/> Asthma, Hay Fever _____
Brothers	_____	_____	_____	_____	<input type="checkbox"/> Cancer _____
	_____	_____	_____	_____	<input type="checkbox"/> Chemical Dependency _____
	_____	_____	_____	_____	<input type="checkbox"/> Diabetes _____
Sisters	_____	_____	_____	_____	<input type="checkbox"/> Heart Disease, Strokes _____
	_____	_____	_____	_____	<input type="checkbox"/> High Blood Pressure _____
	_____	_____	_____	_____	<input type="checkbox"/> Kidney Disease _____
	_____	_____	_____	_____	<input type="checkbox"/> Tuberculosis _____
					<input type="checkbox"/> Other _____

HOSPITALIZATION / SURGERIES

Year	Hospital	Reason for Hospitalization and Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

PREGNANCIES

Year of Birth	Sex of Birth	Complications if any
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH HABITS - Check which you use and how much you use.

Caffeine _____ Tobacco _____
 Street Drugs _____ Alcohol _____

OCCUPATIONAL - Check if your work exposes you to:

Stress _____ Hazardous Substances _____
 Heavy Lifting _____ Other _____

Occupation _____

IMMUNIZATIONS	Date	IMMUNIZATIONS	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ Signature of Patient, Parent, Guardian or Personal Representative	_____ Date
_____ Please print name of Patient, Parent, Guardian or Personal Representative	_____ Relationship to Patient
_____ Reviewed By	_____ Date