

**– Family History –**

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

**– Hospitalizations –**

Year	Hospital	Reason for Hospitalization and Outcome

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

Serious Illness/Injuries	Date	Outcome

**– 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	
	Other	

**– Occupational –**

Check (✓) if your work exposes you to:

	Stress	Hazardous Substances
	Heavy Lifting	Other
Occupation _____		

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