~ Family History ~

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

~ Hospitalizations ~

Year	Hospital	Reason for hospital stay and outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate date(s) _____

Serious Illness / Injury	Date	Outcome

~ Pregnancies ~

Year of Birth	Sex	Any Complications

~ 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 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