

All information is strictly confidential

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:	
					Disease	Relations 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

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describes how much you use.

Caffeine	
Tobacco	
Street Drugs	
Other	

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

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

Street	
Hazardous Substances	
Heavy Lifting	
Other	
Your 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

 Please print name of Patient, Parent, Guardian or Personal Representative

 Reviewed By

 Date

 Relationship to Patient

 Date