

FAMILY HISTORY

Relationship	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	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS				Pregnancies		
Year	Hospital	Reason for Hospitalization and Outcome		Year of Birth	Sex	Complications, if any
				HEALTH HABITS		
Have you ever had a blood transfusion? € Yes € No If yes, please give approximate dates _____				Check (√) which substances you use and describe how much you use		
SERIOUS ILLNESS/INJURIES		DATE	OUTCOME		Caffeine	
					Tobacco	
					Drugs	
					Alcohol	
				OCCUPATIONAL		
				Check (√) if your work exposes you to the following		
					Stress	Hazardous Substances
					Heavy Lifting	Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made on this form.

Signature

Date

Reviewed By

Date