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 |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| | | | | |

**Check (✓) if, your blood relatives had any of the following:**

| | Disease | Relationship to you |
|---|---|---|
| | Arthritis, Gout | |
| | Asthma, Hay Fever | |
| | Cancer | |
| | Chemical Dependency | |
| | Diabetes | |
| | Heart Disease, Strokes | |
| | 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## PREGNANCY HISTORY

| Year of Birth | Sex of Birth | Complications if any |
|---|---|---|
| | | |
| | | |
| | | |

## HEALTH HABITS

Check (✓) which substances you use and describe how much you use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Street Drugs | |
| | Other | |
| | | |

## OCCUPATIONAL CONCERNS

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

| | |
|---|---|
| | Stress |
| | 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

Date

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

Relationship to Patient

Reviewed By

Date