– Family History –

Fill in health information about your 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

– Pregnancies –

Year of Birth	Sex of Birth	Complications if any

– Health Habits –

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

	Caffeine	
	Tobacco	
	Drugs	
	Other	

– Occupational –

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

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

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 in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date