Patient Name: _____ **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 relative 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/ Surgeries

Year	Hospital Treating Physician	Reason for Hospitalization/Surgery & Outcome

Health Habits

Check (✓) which substances you use & describe how much you use

	Caffeine	
	Tobacco	
	Recreational Drugs	
	Alcohol	

Occupational

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

	Stress		**Hazardous Material**
	Heavy Lifting		**Other**

Occupation: _____

Are you currently working? YES NO

If released from work:

By Whom?_____ When: _____

Why?_____

_____

Have you ever had a blood transfusion? YES NO

Please give approximate dates: _____

Serious Illness/Injuries	Date	Outcome

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any members of their staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

Review Signature _____ Date _____