

FAMILY HISTORY

Please indicate if any of your blood relatives have had any of the following:

Relation	Age	State of Health	Age of Death	Cause of Death	Condition	Relationship
Father					Arthritis	
Mother					Asthma	
Brother 1					Cancer	
Brother 2					Chemical Dependency	
Brother 3					Diabetes	
Brother 4					Gout	
Brother 5					Hay Fever	
Sister 1					Heart Disease	
Sister 2					High Blood Pressure	
Sister 3					Kidney	
Sister 4					Stroke	
Sister 5					Tuberculosis	

HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES, SURGERIES

Date	Reason	Outcome

PREGNANCIES

Year of Birth	Sex of Birth	Complications (If Any)

MEDICATIONS: (List all medications you are currently taking and the frequency of use)

ALLERGIES: (List all allergies known)

HEALTH HABITS: (Indicate if you use any of the following substances and the frequency of use)

Alcohol: _____ Tobacco: _____
Caffeine: _____ Drugs: _____

OCCUPATIONAL: (Indicate if you are or have been exposed to the following at any job)

Stress _____ Heavy Lifting _____ Hazardous Substances _____ Current 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 of Patient/Parent/Guardian

Date