

**FAMILY HISTORY: Fill in health information about your family**

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following:	
Father					√	Disease
Mother						Arthritis, Gout
Brothers						Asthma, Hay Fever
						Cancer
						Chemical Dependency
						Diabetes
Sisters						Heart Disease, Strokes
						High Blood Pressure
						Kidney Disease
						Tuberculosis
						Other

**HOSPITALIZATIONS**

**PREGNANCY HISTORY**

Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Child	Complications if any

Have you ever had a blood transfusion? <sup>↑</sup> Yes <sup>↑</sup> No  
 If yes, please give approximate date: \_\_\_\_\_

**HEALTH HABITS** Check (√) which substances you use and describe how much you use

**SERIOUS ILLNESS/INJURIES**

Serious Illness/Injuries	Date	Outcome	Caffeine
			Tobacco
			Drugs
			Other

**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following:

			Stress
			Hazardous Substances
			Heavy Lifting
			Other

Your 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.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_