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: Disease	Relationship to you.
Father						Arthritis
Mother						Asthma, Hay Fever
Brothers						Cancer
						Chemical Dependency
						Diabetes
						Heart Disease, Strokes
Sisters						High Blood Pressure
						Kidney Disease
						Tuberculosis
						Other

Hospitalizations

Year	Hospital	Reason for Hospitalization & 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