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
Father				
Mother				
Brother 1				
Brother 2				
Brother 3				
Brother 4				
Brother 5				
Sister 1				
Sister 2				
Sister 3				
Sister 4				
Sister 5				

Condition	Relationship
Arthritis	
Asthma	
Cancer	
Chemical Dependency	
Diabetes	
Gout	
Hay Fever	
Heart Disease	
High Blood Pressure	
Kidney	
Stroke	
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**