# Family History

Fill in health information about your immediate 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, Gout | |
| 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 and 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 you use and how much you use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Street Drugs | |
| | Other | |

# Occupational

Check (✓) if your work exposes you to:

| | | | |
|---|---|---|---|
| | Stress | | Hazardous Substances |
| | Heavy Lifting | | Other |

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date