FAMILY MEDICAL HISTORY

PATIENT NAME: **DATE: / /**

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√), if your blood relatives had any of the following:

	Disease	Relation To You
	Arthritis, Gout, Sickle Cell	
	Cystic Fibrosis	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Osteoporosis	
	Birth Defects	
	Mental Retardation	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion?

Have you ever been hit or threatened by your husband/partner?

SERIOUS ILLNESSES / INJURIES

	DATE	OUTCOME

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

	Caffeine
	Tobacco
	Drugs
	Other
	Exercise
	Folic Acid

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Vaginal or C Section	Full Term Early / Late	Length of Labor	Complications if any

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

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

I certify the the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature Date

Reviewed By Date