

Name _____ Date ___ / ___ / ___ Age _____ Birth Date ___ / ___ / ___

List All Persons Living in Your Household

Name	Relation	Birth Yr.
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Have you, or a blood relative had any of the following?
(If you have ailment please give date of onset)

	You	Year	Other	Relationship
Diabetes				
Cancer				
High Blood Pressure				
Heart Trouble				
Asthma				
Seizures				
Stroke				
Glaucoma				
Migraines				
Venereal Disease				
Alcoholism				
Anemia				
Mental Illness				
Kidney/Bladder				
Hepatitis				
Stomach/Bowel				
Arthritis				
Hemophilia				
Gout				
Tuberculosis				

Number of times pregnant _____
Please list any other health info not listed above:

Operations: Type Year

1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations: (other than operations/childbirth)

- | Reason | Month/Yr |
|----------|----------|
| 1. _____ | |
| 2. _____ | |
| 3. _____ | |
| 4. _____ | |

Allergies to Medication Reaction

1. _____
2. _____
3. _____

Medication taken frequently (Dose/times per day)

1. _____
2. _____
3. _____
4. _____

Immunizations: Flu _____ Year _____
Tetanus _____ Year _____
Pneumorax _____ Year _____

Smoker: Yes _____ No _____
Cigarettes/day _____ for how many yrs _____

Alcohol: Yes _____ No _____
Liquor _____ drinks per _____ for _____ yrs
Beer _____ drinks per _____ for _____ yrs
Wine _____ drinks per _____ for _____ yrs

Other: _____

***Females Only: Obstetrical History**

Full term pregnancies _____ Normal _____ Caesarean _____
Premature deliveries _____ Abortions/miscarriages _____

Check any that apply during pregnancy:

High blood pressure _____
Pre-eclampsia/eclampsia _____
Diabetes _____