FAMILY AND PERSONAL HEALTH HISTORY

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name _____ Age _____ Birth date _____ Today's Date _____

Occupation _____ Last Physical Examination Date _____ Daytime Phone _____

FAMILY RECORD Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism								
Allergies								
Anemia								
Arthritis								
Asthma								
Birth Defects								
Bleeding Tendency								
Cancer, tumor								
Colitis								
Congenital Heart								
Diabetes								
Emphysema								
Epilepsy								
Glaucoma								
Goiter								
Hay Fever								
Heart Attack								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Leukemia								
Liver Disease								
Mental Illness								
Migraine								
Nervous Breakdown								
Obesity								
Rheumatism								
Rheumatic Fever								
Sickle-Cell Anemia								
Stomach Ulcer								
Stroke								
Suicide								
Tuberculosis								

FAMILY MEMBERS

	Living				Deceased		
	AGE	Health ✓ Good	✓ Fair	✓ Poor	DEATH	AGE	Cause of Death
Father							
Mother							
Brother(s)							
Sister(s)							

OPERATIONS	✔ Yes	✔ No	Date
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast (women)			
Uterus (women)			
Ovaries (women)			
Prostate (men)			
Other - If yes, what:			

Do You: If yes, daily consumption				
Smoke	Pkgs.			
Drink Coffee	Cups			
Beer	ozs.			
Hard liquor	ozs.			

IMMUNIZATIONS			
Pneumonia Vaccine			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Other - If yes, what:			

X-RAYS			
When was last mammogram?			
Back			
Chest			
Colon			
Extremities			
Gall Bladder			
Kidney			
Stomach			
Treatments			
Other - If yes, what:			

Doctor's Use Only — Summary