Patient Name: ______________________ DOB: ______________

ALL INFORMATION IS STRICTLY CONFIDENTIAL

FAMILY HISTORY Fill in Health information about your immediate family.

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	Relationship to you
☐	Arthritis, Gout	
☐	Asthma, Hay Fever	
☐	Breast Cancer	
☐	Cancer	
☐	Chemical Dependency	
☐	Diabetes	
☐	Heart Disease, Strokes	
☐	High Blood Pressure	
☐	Kidney Disease	
☐	Tuberculosis	
☐	Other	

PRIOR OPERATIONS (INCLUDING COSMETIC)

Year	Hospital	Reason for operation and outcome

PREGNANCY HISTORY

Year	Sex	Complications, if any

MEDICAL CONDITIONS

Please list any medical conditions, the date, and the outcome

Condition	Date	Outcome

Have you ever had a blood transfusion? ______________
If yes, please give approximate date

HEALTH HABITS

Check ✓ which substance you use and describe the amount

	Substance	Amount
☐	Caffeine	
☐	Tobacco	
☐	Street Drugs	
☐	Alcohol	
☐	Other	

OCCUPATIONAL CONCERNS

Check ✓ if your work exposes you to the following

- ☐ Stress
- ☐ Hazardous Substances
- ☐ Heavy Lifting
- ☐ Other

Your 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