ALL INFORMATION IS STRICTLY CONFIDENTIAL

FAMILY HISTORY: Fill in health information about your immediate family									
Relation	**Age**	**State of Health**		**Cause of Death**	**Circle if your blood relative had any of the following**				
		Good, Bad or Fair			**Disease**		**Relationship to you**		
Father					Arthritis				
Mother					Asthma				
Sisters					Cancer				
					Chemical Dependency				
					Diabetes				
					Heart Disease				
					Stroke				
					High Blood Pressure				
Brothers					Kidney Disease				
					Tuberculosis				
					Gout				
					Hay Fever				
					Other				

HOSPITALIZATION			PREGANCY HISTORY		
Year	**Hospital**	**Reason for hospitalization and outcome**	**Year of Birth**	**Sex of Baby**	**Complications**
			HEALTH HABITS Circle and describe how much use		
			Caffine		
Have you ever had a blood transfusion? Yes No			Tobacco		
If yes please give approximate dates.			Street Drugs		

SERIOUS ILLNESS/INJURIES	**Date**	**Outcome**	Other	
			OCCUPATIONAL CONCERNS	
			Circle 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
Review by	Date