



**FAMILY HISTORY**

CHECK IF ANY BLOOD RELATIVES HAVE HAD:

Relation	Age	State of Health	Age at Death	Cause of Death	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					High Cholesterol	
					Thyroid Disease	
					Other	

**HOSPITALIZATIONS**

**PREGNANCY HISTORY**

Year	Hospital	Reason for Hospitalization	Date of Birth	Complications if any

**SERIOUS ILLNESS/INJURIES**

**HEALTH HABITS**

Description	Date	Outcome	Substance	How much use
			Caffeine	
			Tobacco	
			Drugs	
			Other	
			<b>Occupational</b>	
			Stress	
			Hazardous Substances	
			Heavy Lifting	
			Other	

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date