(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

If yes, please give approximate dates _____

SERIOUS ILLNESS / INJURIES

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications, if any

HEALTH HABITS

Check (✔) which substances you use and describe how much you use

	Caffeine	
	Tobacco	
	Drugs	
	Others	

OCCUPATIONAL CONCERNS

Check (✔) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

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

Signature _____ Date _____

Reviewed by _____ Date _____