FAMILY HISTORY *Fill in health information about your family*

	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
❏ Arthritis, Gout	______
❏ Asthma, Hay Fever	______
❏ Cancer	______
❏ Chemical Dependency	______
❏ Diabetes	______
❏ Heart Disease, Strokes	______
❏ 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	Date	Outcome

PREGNANCIES

YEAR OF BIRTH	SEX OF BIRTH	COMPLICATIONS, IF ANY

LIFESTYLE/HABITS

Check ✔ habits that apply and write the frequency

❏ Caffeine ______

❏ Tobacco ______

❏ Alcohol ______

❏ Drugs ______

❏ Exercise ______

❏ Vitamins ______

OCCUPATIONAL

Occupation ______

Check ✔ if your work exposes you to the following:

❏ Stress ❏ Heavy Lifting

❏ Hazardous Substances ❏ Other

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 the completion of this form.

Signature ______ Date ______

Reviewed By ______ Date ______