FAMILY AND PERSONAL HEALTH HISTORY

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission

Name________________________________Age_____Birth Date_______________Todays Date___________

Occupation_____________________________Last Physical Exam_____________Phone #_______________

Medication List

Drugs/Prescriptions	Dose	Refill

OPERATIONS	Yes	**No**	**Date**
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast (woman)			
Uterus (woman)			
Ovaries (woman)			
Prostate (men)			
Other - if yes what:			

Do You: (if yes, daily consumption)

	Yes	No	How Much
Smoke Pkgs.			
Drink Coffee Cups			
Beer ozs.			
Hard liquor ozs.			

Family Record Check condition(s) and relationship of any blood relative who has or has had any of the conditions listed below	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism								
Allergies								
Arthritis								
Asthma								
Birth Defects								
Bleeding Tendency								
Cancer, Tumor								
Colitis								
Congenital Heart								
Diabetes								
Emphysema								
Epilepsy								
Glaucoma								
Goiter								
Hay Fever								
Heart Attack								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Leukemia								
Liver Disease								
Mental Illness								
Migraine								
Nervous Breakdown								
Obesity								
Rheumatism								
Rheumatic Fever								
Sickle Cell Anemia								
Stomach Ulcer								
Stroke								
Suicide								
Tuberculosis								

Family Members Living Age and Health

	AGE	GOOD	FAIR	POOR
Father				
Mother				
Brother(s)				
Sister(s)				

Family Members Deceased

	Cause of Death
Father	
Mother	
Brother(s)	
Sister(s)	

PAST AND PRESENT MEDICAL PROBLEMS

Check all items either yes or no and give approximate date if past	No	Yes Now	Yes Past	If Past date
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (type)				
Arthritis				
Blindness Either Eye				
Broken Bones				
Cataracts				
Chronic Bronchitis/Lung Disease				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Deafness				
Dysentery				
Ear Infections				
Diabetes				
Emphysema				
Enlarged Heart				
Glaucoma				
Gall Stones				
Gout				
Goiter				
Gonorrhea				
Hay Fever				
Heart Murmur as Adult				
Heart Attack				
High Blood Pressure				
Hepatitis				
Hemorrhoids				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Polio				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach or Duodenal Ulcer				
Syphilis				

yes or no and give approximate date if past	No	Yes Now	Yes Past	If Past Date
Skin Disease				
Serious Depression				
Serious Emotional Prob				
Tuberculosis				
Thyroid (overactive)				
Thyroid (under active)				
Varicose Veins				
Men				
Prostate Problems				
Women				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease				
Still Menstruating?				

Age Period Started:____________________
Age Periods Stopped____________________
Why Periods Stopped____________________
Number of Pregnancies____________________
Number of Children____________________
Number of Miscarriages____________________
Explain:____________________

X-Rays

When was your last Mammogram?

Please list any recent scans you have had done.

	Yes	**No**	**Date**
IMMUNIZATIONS			
Pneumonia Vaccine			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			

Do you have any Allergies, if yes please list ____________________

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Please list Hospitalizations/Reasons and Dates ____________________

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