MEDICAL HISTORY

FAMILY HISTORY	LIVING	AGE	DECEASED	CAUSE OF DEATH
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Brothers	_____	_____	_____	_____

HAS ANYONE IN YOUR FAMILY EVER HAD (INCLUDING GRANDPARENTS):

Cancer_____	Heart Disease_____	Kidney Disease_____
Mental Illness_____	Diabetes_____	Ulcers_____
Tuberculosis_____	Stroke_____	Liver Disease_____
Sickle Cell Disease_____	Asthma_____	Allergy_____
Paralysis_____	Bleeding Tendency_____	

HAVE YOU EVER HAD:

Measles _____	Asthma_____	Anemia_____	Polio_____
Mumps _____	Pneumonia_____	Hives_____	Allergy_____
Chicken Pox_____	Jaundice_____	Meningitis_____	Influenza_____
Whooping Cough_____	Encephalitis_____	Epilepsy_____	Hepatitis_____
Scarlet Fever_____	Hay Fever_____	Cancer_____	Diabetes_____
Rheumatic Fever_____	Tuberculosis_____	Stroke_____	Diptheria_____
Thyphoid Fever_____	Heart Disease_____	Venereal Disease_____	

Do you smoke? No_____ Yes_____ Packs per day_____ Years_____
Alcoholic Beverages (Circle one) None Rarely Moderately Daily Quit
List any past serious illnesses (Give details) _____

_____

List all past operations (Give type, date & doctors name) _____

_____

_____

Have you had any accidents, falls or fractures in the past? (List type, date & doctors name)_____

_____

List Current Medications: _____

Signature_____ Date_____

_____ _____
(Signature of consenting parent or guardian, if patient is a minor) Relationship