

MEDICAL HISTORY

<u>FAMILY HISTORY</u>	<u>LIVING</u>	<u>AGE</u>	<u>DECEASED</u>	<u>CAUSE OF DEATH</u>
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 _____	Diphtheria _____
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