FAMILY AND SELF HISTORY Today's Date: _____

Patient Name: _____ Date of Birth: _____

Have you or any blood relative ever had:

	You ✓	Family ✓
Heart Attacks	___	___
Serious Heart Trouble	___	___
High Blood Pressure	___	___
Strokes	___	___
Leukemia	___	___
Other (Cancer)	___	___
Diabetes (High Sugar)	___	___
Thyroid Disease/Goiter	___	___
Glaucoma	___	___
Migraine Headaches	___	___
Motion Sickness	___	___
Cataracts	___	___
Color Blindness	___	___
Alcoholism/Alcohol Abuse	___	___
Anemia (Low Blood Count)	___	___
Easy Bleeding Problem	___	___
Epilepsy (Seizures)	___	___
Mental Nervous Disorders	___	___
Tuberculosis/Exposure to TB	___	___
Pneumonia	___	___
Emphysema	___	___
Influenza	___	___
Blood Clot to Lung	___	___
Pleurisy	___	___
Stomach Ulcer	___	___
Gallbladder Disease	___	___
Hepatitis/Yellow Jaundice	___	___
Liver Disease/Cirrhosis	___	___
Bowl Disease	___	___
Hemorrhoids/Rectal Problems	___	___
Hernia	___	___
Kidney Disease	___	___
Kidney Infection	___	___
Bladder Infection	___	___
Prostate Trouble (Men)	___	___
Gonorrhea or Syphilis	___	___
Arthritis or Rheumatism	___	___
Any Bone or Joint Disease	___	___
Rheumatic Fever	___	___
Polio or Meningitis	___	___
Hay Fever or Asthma	___	___
Hives or Eczema	___	___
Any other Diseases?	___	___

Weight:
Now _____
One Yr Ago _____
Heaviest _____
When _____

Smoking:
How many/day? _____
How many/Yrs? _____
Snuff _____
Tobacco _____

Beverages (amount/week):
Liquor _____
Beer _____
Wine _____
Coffee _____

Past Drug Abuse:
Illicit/Street drugs? **Y / N**
Prescription drugs? **Y / N**

OB/GYN:
# of Pregnancies _____
C-Sections _____
Miscarriages _____
Live Births _____
Premature Babies _____
Abortions _____
When? _____

Any Pregnancy Problems?
_____
_____
_____
_____
_____
_____
_____
_____

Past Menopause? Y / N

Surgeries: Have you ever had surgery or been operated on for:

	✓	Year
Skin Cancer	___	_____
Appendix	___	_____
Tonsils	___	_____
Gallbladder	___	_____
Hernia	___	_____
Hemorrhoids	___	_____
Breast/Lump	___	_____
Female Organs	___	_____
Prostate	___	_____
Other:	___	_____

Other Hospitalizations:

Reason	**Year**
_____	_____
_____	_____
_____	_____

Personal History-Have YOU ever had:

Measles 3 day (Rubella) _____
Measles 10 day _____
Mumps _____
Chicken Pox _____
Scarlet Fever/Scarlatina _____
Mononucleosis (Mono) _____

Allergies to:

Penicillin _____
Sulfa _____
Other Medicine _____
Other Food _____
Other _____

Food/Chemical/Drug Poisoning _____
Blood or Plasma Transfusion _____
Broken or Cracked Bones _____
Sprains or Dislocations _____
Lacerations Needing Sutures _____
Concussions or Head Injury _____
Injury to eye or ears _____

Use of:

Hearing Aid _____
Removable Dentures _____
Glasses/Contacts _____

Recommended Surgery that HAS NOT been done _____