

PAST MEDICAL HISTORY:

Date: _____

Hospitalizations (include year and reason): _____

Operations (include year and type): _____

Other serious illnesses (e.g. rheumatic fever): _____

Allergies (drugs and other): _____

Present medications: _____

FAMILY HISTORY:

Relation	Name	State of Health	Cause of Death	Age at Death
Father				
Mother				
Siblings				
Spouse				
Children				

MEDICAL REVIEW: (✓ those that apply)

Disease	Self	Family	Disease	Self	Family
Alcoholism or Drug Addiction			Heart Disease (HEART ATTACK, ANGINA, FAILURE)		
Asthma or Hayfever			High Blood Pressure		
Cancer or Leukemia			Kidney Disease (INFECTIONS, STONES, NEPHRITIS)		
Convulsions or Seizures			Liver Disease (HEPATITIS, JAUNDICE)		
Diabetes			Smoking		
Emphysema or Bronchitis			Stroke		
Gallbladder or Ulcer Disease			Thyroid (Goiter)		

Patient: _____ # _____