FAMILY HISTORY

PLEASE LIST ANY OTHER MEDICAL/ SURGICAL CONDITION, OR COMMENT ON ANY OF THE ABOVE:

FAMILY HISTORY

MOTHER: AGE ☐ DECEASED? ☐

ILLNESSES

GENERAL HEALTH

FATHER AGE ☐ DECEASED? ☐

ILLNESSES:

GENERAL HEALTH:

BROTHER(S) AGE(S) DECEASED? ☐
SISTER(S)

ILLNESSES:

GENERAL HEALTH:

PLEASE INCLUDE CANCER, DIABETES, HEART ATTACKS, BLOOD PRESSURE, STROKES, TB AND ANY IMPORTANT ILLNESSES.

DO YOU SMOKE? YES NO HOW MUCH?

NUMBER OF YEARS? CIGARETTES

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO

WHAT KIND? HOW OFTEN?

FOR FEMALES ONLY: ARE YOU PREGNANT? YES NO

DATE OF LAST MESTRUAL CYCLE

SIGNATURE OF PERSON
COPLETING HEALTH HISTORY