Name_____ Age_____ Birthdate_____

Occupation_____ Daytime Phone_____

Today's Date_____ Last Physical Exam Date _____

FAMILY RECORD Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.

	Y	N	DAD	MOM	SIS	BRO	DAU	SON
ALCOHOLISM								
ALLERGIES								
ANEMIA								
ANGINA (CHEST PAIN)								
ARTHRITIS								
ASTHMA								
† BLOOD PRESSURE								
CANCER								
CATARACTS								
CHRONIC BRONCHITIS								
COLITIS								
CONGENITAL HEART DEFECTS								
DIABETES								
EAR INFECTIONS								
EMPHYSEMA								
EPILEPSY								
GOITER								
GALLBLADDER DISEASE								
HEADACHES								
HEART DISEASE								
KIDNEY DISEASE								
LIVER DISEASE								
STOMACH ULCER								
SUICIDE								
TUBERCULOSIS								
MALES PROSTATE PROBLEMS								
FEMALES MENSTRUAL DIFFICULTIES								
MASTITIS (BREAST INFECTION)								
OVARIAN CYST								
BREAST CANCER								
AGE PERIOD STARTED								
AGE PERIOD STOPPED								
NUMBER OF PREGNANCIES								
NUMBER OF CHILDREN								
NUMBER OF MISCARRIAGES								

FAMILY MEMBERS

	LIVING					DECEASED	
	AGE	HEALTH Good → Poor				AGE	Cause of Death
Spouse							
Mother							
Father							
Bros.							
(1)							
(2)							
(3)							
Sister							
(1)							
(2)							
(3)							
Sons							
(1)							
(2)							
(3)							
Daugh							
(1)							
(2)							
(3)							

DO YOU: If yes, daily consumption				
SMOKE	PKGS			
DRINK COFFEE	CUPS			
BEER	OZS.			
HARD LIQUOR	OZS.			

ALLERGIES

Have you been hospitalized?

If yes, what for?