Family History

Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Have any of your relatives ever had?	Please Check Yes	No	Relationship to you
					Asthma			
Father					Heart Disease			
Mother					Cancer			
Brothers					Glaucoma			
					Diabetes			
					Stroke			
Sisters					High Blood Pressure			
					Kidney Disease			
					Other:			

Hospitalizations/Surgeries

Year	***Name of hospital or facility***	***Reason for hospitalization and outcomes***

Social & Behavioral Habits

	Frequency				
	Never	Previously		Currently	
		Rarely	Daily	Daily	Rarely
Cigarettes					
Other Tobacco					
Non Prescribed Drugs					
Alcohol					
Caffeine					

Occupational Exposure History

	Frequency				
	Never	Previously		Currently	
		Rarely	Daily	Rarely	Daily
Heavy lifting					
Hazardous Substance					
Stress					
Other:					

Have you ever had a blood transfusion? ☐ No ☐ Yes Dates: ______________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ______________________

Signature Date