



MEDICAL HISTORY

Today's Date ____/____/____

Name _____ Date of Birth _____
 Last First MI Month Day Year

Gender ____ F ____ M Single ____ Married ____ Partner ____ Widowed ____ Divorced ____

Number of years of education completed _____

Are/were you in the military? ____ Yes ____ No Veteran of _____ # years Medical discharge ____ Yes ____ No

FAMILY MEDICAL HISTORY

Do you have any blood relatives who have or have had any of the listed conditions? Please check all that apply.

	Yes	No	Relationship
Cancer	___	___	_____
Epilepsy	___	___	_____
Heart attack	___	___	_____
Heart disease	___	___	_____
HIV/AIDS	___	___	_____
Kidney Disease	___	___	_____
Liver disease	___	___	_____
Multiple Sclerosis	___	___	_____
TB	___	___	_____

FAMILY MEMBERS

	If Living				If Deceased	
	Health				Cause of Death, if known	Age at time of death
	Age	Good	Fair	Poor		
Mother						
Father						
Sisters and Brothers						
Children						

PERSONAL MEDICAL HISTORY

Do you have or have you had any of these medical conditions? Please check all that apply.

- | | | | |
|---|--|---|------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Alcohol/drug addiction | Other _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Nervous breakdown | _____ |
| <input type="checkbox"/> TB | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental/emotional illness | _____ Last chest X-ray |
| <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Are you pregnant? | _____ Last mammogram |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Breast Feeding? | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Low Blood pressure | | |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | | |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Multiple sclerosis | | |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | | |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Migraines | | |
| <input type="checkbox"/> Congenital Heart problem | <input type="checkbox"/> Alzheimer's Disease | | |

List any surgery, accident, injury, medical condition or disease that required hospitalization in the past five years.

_____ Year _____
 _____ Year _____
 _____ Year _____
 Other _____ Year _____
 _____ Year _____