

NAME \_\_\_\_\_ DATE \_\_\_\_\_ AGE \_\_\_\_\_

**MEDICAL ILLNESSES:** (IF YOU HAVE HAD ANY OF THE FOLLOWING, CHECK THE BOX)

CHILDHOOD ILLNESSES

- MUMPS
- MEASLES-GERMAN (RUBELLA)
- MEASLES-REGULAR
- CHICKENPOX
- RADIATION FOR TONSILS,  
ACNE OR THYMUS
- SCARLET FEVER
- RHEUMATIC FEVER
- POLIO
- OTHER \_\_\_\_\_

RUBELLA VACCINE:  
YES \_\_\_\_\_ NO \_\_\_\_\_ WHEN \_\_\_\_\_

LAST TETANUS SHOT: \_\_\_\_\_

HAVE YOU EVER RECEIVED BLOOD  
TRANSFUSION?  
YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU DRINK ALCOHOL?  
YES \_\_\_\_\_ NO \_\_\_\_\_  
HOW OFTEN AND HOW MUCH?  
\_\_\_\_\_

DO YOU USE TOBACCO?  
YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, HOW MUCH? \_\_\_\_\_

IF NO, HAVE YOU EVER SMOKED?  
YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHEN DID YOU QUIT?  
\_\_\_\_\_

OTHER ILLNESSES

- ANEMIA
- ARTHRITIS
- ASTHMA
- BLEEDING DISORDER
- BRONCHITIS OR PNEUMONIA
- CANCER (TUMOR)
- HIGH CHOLESTEROL  
OR TRIGLYCERIDES
- COLON OR INTESTINAL  
PROBLEMS (COLITIS)
- COLON POLYPS
- DEPRESSION
- DIABETES
- DIVERTICULOSIS OR  
DIVERTICULITIS
- EMPHYSEMA
- EPILEPSY (SEIZURES)
- EYE PROBLEMS
- GALL BLADDER DISEASE
- GLAUCOMA
- HAY FEVER (ALLERGIES)
- HEART ATTACK
- HEART DISEASE
- HEART MURMUR
- HEMORRHOIDS
- HERNIA
- HIGH BLOOD PRESSURE  
(HYPERTENSION)
- H.I.V. OR AIDS

- JAUNDICE (YELLOW)
- KIDNEY OR BLADDER DISEASE
- LIVER DISEASE (HEPATITIS)
- LUNG DISEASE
- LUPUS
- MALARIA
- MENTAL ILLNESS
- MITRAL VALVE PROLAPSE
- MONO
- NEURALGIA / NEURITIS
- NERVOUS BREAKDOWN
- PHLEBITIS (BLOOD CLOTS)
- PROSTATE DISORDER
- RHEUMATIC DISEASE  
(COLLAGEN DISEASE)
- SEXUALLY TRANSMITTED  
(VENEREAL) DISEASE
- SKIN DISEASE
- STROKE/TRANSIENT ISCHEMIC  
ATTACK
- SUICIDE ATTEMPT
- THYROID DISEASE
- TUBERCULOSIS (TB)
- ULCER/STOMACH DISORDER
- VASCULAR DISEASE (BLOOD  
VESSEL OR CIRCULATION  
DISORDER)

PLEASE LIST ANY MEDICAL ILLNESS YOU HAVE HAD THAT WERE NOT LISTED ABOVE:

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

MEDICINES: (LIST ALL MEDICATION, BIRTH CONTROL PILLS, VITAMINS, ETC. THAT YOU TAKE WITH OR WITHOUT A PRESCRIPTION.)

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

ALLERGIES TO MEDICATION: (LIST ALL MEDICATION THAT YOU ARE ALLERGIC TO, AND INCLUDE WHAT TYPE OF REACTION-RASH, HIVES, SWELLING, ETC.)

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**SURGICAL HISTORY:** (IF YOU HAVE HAD ANY OF THE FOLLOWING SURGICAL PROCEDURES, PLEASE CHECK THE APPROPRIATE BOX, AND GIVE THE YEAR.)

	YEAR				YEAR
<input type="checkbox"/> APPENDECTOMY	_____		<input type="checkbox"/> HEART BYPASS	_____	
<input type="checkbox"/> ANGIOPLASTY	_____		<input type="checkbox"/> HERNIA	_____	
<input type="checkbox"/> ARTHROSCOPY	_____		<input type="checkbox"/> HYSTERECTOMY	_____	
<input type="checkbox"/> BIOPSY OF:	_____		(WERE BOTH		
_____	_____		OVARIES REMOVED		
_____	_____		ALSO?)	YES _____	NO _____
<input type="checkbox"/> C-SECTION(S) # _____	_____		<input type="checkbox"/> ORTHOPEDIC SURGERY	_____	
<input type="checkbox"/> COLONOSCOPY	_____		<input type="checkbox"/> PROSTATE	_____	
<input type="checkbox"/> CYSTOSCOPY	_____		<input type="checkbox"/> TONSILS	_____	
<input type="checkbox"/> D&C(S) # _____	_____		<input type="checkbox"/> TUBAL LIGATION	_____	
<input type="checkbox"/> GALLBLADDER	_____		(FALLOPIAN TUBES)		
			<input type="checkbox"/> VASECTOMY	_____	
			<input type="checkbox"/> VASCULAR SURGERY	_____	

**PLEASE LIST:** ANY ADDITIONAL SURGICAL PROCEDURES OR OPERATIONS YOU HAVE HAD THAT WERE NOT LISTED ABOVE.

	YEAR				YEAR
1. _____	_____		4. _____	_____	
2. _____	_____		5. _____	_____	
3. _____	_____		6. _____	_____	

**FAMILY HISTORY:** (FOR EACH FAMILY MEMBER CHECK THE BOX(ES) THAT APPLY.)

FAMILY MEMBER	LIVING	DECEASED - AGE & CAUSE OF DEATH	HEART DISEASE	HIGH BLOOD PRESSURE	DIABETES	CANCER	OTHER (PLEASE LIST)
FATHER:							
MOTHER:							
SISTERS/BROTHERS:							
1.							
2.							
3.							
4.							
5.							
6.							
CHILDREN:							
1.							
2.							
3.							
4.							
5.							
6.							
PATERNAL GF:							
PATERNAL GM:							
MATERNAL GF:							
MATERNAL GM:							
PATERNAL RELATIVES:	in each box, write how many affected with.						
MATERNAL RELATIVES:	in each box, write how many affected with.						