

NAME _____ DATE OF BIRTH _____ DATE _____

FAMILY HISTORY:

Father _____

Living _____ If so, what medical problems does he have? _____

Deceased _____ If so, how old was he when he died? _____ What was the cause of death? _____

Mother _____

Living _____ If so, what medical problems does she have? _____

Deceased _____ If so, how old was she when she died? _____ What was the cause of death? _____

Brothers and Sisters _____

Living _____ What medical problems do they have? _____

Deceased _____ What was the age at and cause of death? _____

Sons (How many? _____) and daughters (How many? _____)

Living _____ What medical problems do they have? _____

Deceased _____ What was the age at and cause of death? _____

Has any relative ever had

	No	Yes	Who		No	Yes	Who
CANCER	_____	_____	_____	Stroke	_____	_____	_____
DIABETES	_____	_____	_____	Suicide	_____	_____	_____
Tuberculosis	_____	_____	_____	Mental Illness	_____	_____	_____
Heart trouble	_____	_____	_____	Multiple births	_____	_____	_____
High blood pressure ..	_____	_____	_____	Babies deformed at birth ..	_____	_____	_____

PERSONAL HISTORY:

Menstrual: age at onset _____ Regular: No _____ Yes _____ Cycle _____ days (from start to start). Usual duration _____ days. Flow light _____ moderate _____ heavy _____ Clots No _____ Yes _____ Pain or cramps No _____ Yes _____ If menopausal, when was your last period? _____

Pregnancy (if appropriate) Number miscarried _____ Number stillborn _____ Longest labor _____ hrs. Number of babies 9 lbs. or over at birth _____

Medical

Have you ever received blood transfusions? No _____ Yes _____ How many? _____

What medicine are you now on? _____

Are you ALLERGIC to any medication? No _____ Yes _____ What _____

Alcoholic beverages Never _____ Occasional _____ Daily _____

Cigarettes _____ packs per day _____

When was last chest x-ray? _____

Any significant weight gain or loss recently? No _____ Yes _____

Surgical

When _____ Where _____ What _____ Why _____

Any serious complications? _____

