# FAMILY AND PERSONAL HEALTH HISTORY

**Note:** Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name ______________________ Age ____ Birth date ____________ Today's Date ____________

Occupation ____________ Last Physical Examination Date ____________ Daytime Phone ____________

| **FAMILY RECORD** Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below. | YES | NO | FATHER | MOTHER | BROTHER | SISTER | SON | DAUGHTER |
|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | |
| Allergies | | | | | | | | |
| Anemia | | | | | | | | |
| Arthritis | | | | | | | | |
| Asthma | | | | | | | | |
| Birth Defects | | | | | | | | |
| Bleeding Tendency | | | | | | | | |
| Cancer, tumor | | | | | | | | |
| Colitis | | | | | | | | |
| Congenital Heart | | | | | | | | |
| Diabetes | | | | | | | | |
| Emphysema | | | | | | | | |
| Epilepsy | | | | | | | | |
| Glaucoma | | | | | | | | |
| Goiter | | | | | | | | |
| Hay Fever | | | | | | | | |
| Heart Attack | | | | | | | | |
| Heart Disease | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Leukemia | | | | | | | | |
| Liver Disease | | | | | | | | |
| Mental Illness | | | | | | | | |
| Migraine | | | | | | | | |
| Nervous Breakdown | | | | | | | | |
| Obesity | | | | | | | | |
| Rheumatism | | | | | | | | |
| Rheumatic Fever | | | | | | | | |
| Sickle-Cell Anemia | | | | | | | | |
| Stomach Ulcer | | | | | | | | |
| Stroke | | | | | | | | |
| Suicide | | | | | | | | |
| Tuberculosis | | | | | | | | |

**FAMILY MEMBERS**

| Living | | | | | Deceased | |
|---|---|---|---|---|---|---|
| | AGE | Health ✓ Good | ✓ Fair | ✓ Poor | AGE DEATH | Cause of Death |
| Father | | | | | | |
| Mother | | | | | | |
| Brother(s) | | | | | | |
| | | | | | | |
| | | | | | | |
| Sister(s) | | | | | | |
| | | | | | | |
| | | | | | | |

| **OPERATIONS** | ✓ Yes | ✓ No | Date |
|---|---|---|---|
| Tonsils | | | |
| Appendix | | | |
| Gall Bladder | | | |
| Stomach | | | |
| Kidney | | | |
| Colon | | | |
| Thyroid | | | |
| Hernia | | | |
| Breast (women) | | | |
| Uterus (women) | | | |
| Ovaries (women) | | | |
| Prostate (men) | | | |

Other - If yes, what:

| **Do You:** If yes, daily consumption | | | | |
|---|---|---|---|---|
| Smoke | Pkgs. | | | |
| Drink Coffee | Cups | | | |
| Beer | ozs. | | | |
| Hard liquor | ozs. | | | |

| **IMMUNIZATIONS** | | | |
|---|---|---|---|
| Pneumonia Vaccine | | | |
| Tetanus | | | |
| Booster | | | |
| Measles | | | |
| Influenza | | | |
| German Measles/Mumps | | | |

Other - If yes, what:

**X-RAYS**

When was last mammogram?

| | | | |
|---|---|---|---|
| Back | | | |
| Chest | | | |
| Colon | | | |
| Extremities | | | |
| Gall Bladder | | | |
| Kidney | | | |
| Stomach | | | |
| Treatments | | | |

Other - If yes, what:

**Doctor's Use Only — Summary**

# PAST AND PRESENT MEDICAL PROBLEMS

| Check (✓) all items either yes or no and give approximate date if past. | No | Yes Now | Yes Past | If Past Date |
|---|---|---|---|---|
| Asthma | | | | |
| Abnormal Electrocardiogram | | | | |
| Angina | | | | |
| Anemia (Type ) | | | | |
| Arthritis | | | | |
| Blindness Either Eye | | | | |
| Broken Bones | | | | |
| Cataracts | | | | |
| Chronic Bronchitis/Chronic Lung Disease | | | | |
| Cirrhosis of Liver | | | | |
| Colon or Bowel Trouble | | | | |
| Deafness | | | | |
| Dysentery | | | | |
| Diabetes | | | | |
| Ear Infections | | | | |
| Emphysema | | | | |
| Enlarged Heart | | | | |
| Glaucoma | | | | |
| Gall Stones | | | | |
| Gout | | | | |
| Goiter | | | | |
| Gonorrhea | | | | |
| Hay Fever | | | | |
| Heart Murmur as Adult | | | | |
| Heart Attack | | | | |
| High Blood Pressure | | | | |
| Hepatitis | | | | |
| Hemorrhoids | | | | |
| Kidney Infection | | | | |
| Kidney Stones | | | | |
| Nervous Breakdown | | | | |
| Poor Blood Clotting | | | | |
| Polio | | | | |
| Phlebitis | | | | |
| Rheumatic Fever | | | | |
| Rectal Trouble | | | | |
| Recurrent Boils | | | | |
| Stroke | | | | |
| Stomach or Duodenal Ulcer | | | | |
| Syphilis | | | | |

| Check (✓) all items either yes or no and give approximate date if past. | No | Yes Now | Yes Past | If Past Date |
|---|---|---|---|---|
| Skin Disease | | | | |
| Serious Depression | | | | |
| Serious Emotional Problems | | | | |
| Tuberculosis | | | | |
| Thyroid (overactive) | | | | |
| Thyroid (underactive) | | | | |
| Varicose Veins | | | | |
| **Men** | | | | |
| Prostate Problems | | | | |
| **Women** | | | | |
| Menstrual Difficulties | | | | |
| Cystitis | | | | |
| Mastitis | | | | |
| Ovarian Cyst | | | | |
| Breast Cancer | | | | |
| Other Breast Disease* | | | | |
| Other Gynecological Problems* | | | | |
| Still Menstruating | | | | |

Age Period Started ____________

Age Periods Stopped ____________

Why Periods Stopped ____________

Number of Pregnancies ____________

Number of Children ____________

Number of Miscarriages ____________

*Explain:

Hospitalizations/Reason Date

Do you wear artificial devices? Yes No

Please list

Do you have allergies? Yes No

Please list

**Doctor's Use Only — Summary**