Health History

Patient Name:	DOB:	Date:

Family History: fill in health information about your family

Relation	Age	State of Health	Age of Death	Cause of Death	Check if your blood relatives have had any of the following	
Father					Disease	Relationship to You
Mother					Arthritis, Gout	
Brothers					Asthma, Hay Fever	
					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Obesity	
					Tuberculosis	
					Vascular Disease	

Hospitalizations:		**Serious Illness/ Injuries**
Year	**Hospital**	
		Pregnancy History
Health Habits: Check which substance you use and describe how much you use them		**Allergies: To Medications or Substances**
	Caffeine :	
	Tobacco:	
	Alcohol:	
	Drugs:	
	Other:	
Pharmacy Name and Phone:		

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 omission that I may have made in the completion of this form.

Signature:____ **Date:** _______________