HOSPITALIZATIONS OR SURGERIES

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION / SURGERY

PREGNANCY HISTORY

Year of	Sex of Birth	Outcome/Type of Delivery

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate dates: _____

HEALTH HABITS

Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	(packs/day)
	Drugs	
	Alcohol	(drinks/week)
	Other	

OCCUPATIONAL CONCERNS

Check (√) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Contact with Blood or Body Fluids
	Other

Your Occupation:

FAMILY HISTORY

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√) if your blood relatives had any of the following: Disease	Relationship to You
Obesity	
Asthma, Hay Fever	
Cancer and type	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Elevated Cholesterol	
Other	

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____