PATIENT'S FAMILY HISTORY

NAME:_____ DATE OF BIRTH_____
BIRTH PLACE:_____

MOTHER'S AGE:_____ HER DISEASE:_____SMOKER?
_____

FATHER'S AGE:_____ HIS DISEASE;_____SMOKER?
_____

KNOWN FAMILIAL DISEASE:

HABITS:_____
EXERCISE:_____ HOW OFTEN?
_____
ALCOHOL:_____ HOW MUCH?
_____
CIGARETTE:_____ HOW MANY?
_____
DRUGS:_____
HISTORY OF ADDICTION OR DEPENDENCE:
_____
BRIEF DESCRIPTION
_____
DO YOU USE SEATBELT? _____
DO YOU WEAR A BIKE HELMET?
_____
MEDICATION AND SUPPLEMENTS:_____
OPERATION _____
HOSPITALIZATION:_____
ALLEGIES? _____ ASTHMA? _____ HAYFEVER?_____
YEAR OF LAST TETANUS SHOT:_____
IMMUNIZATION:_____ ACTIVE?_____ SAFE? _____
PAST MEDICAL ILLNESS OIR SERIOUS INFECTIONS: _____
PSYCHOLOGICAL PROBLEMS: _____
HIGH LEVEL OF EDUCATION ATTAINED: _____
DO YOU HAVE A LIVING WILL? _____ A HEALTH CARE PROXY? _____
REASON FOR THE VISIT? _____