MEDICATIONS

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Pharmacy Name: _____ Pharmacy Tel: _____

FAMILY HISTORY

***** Fill in the Health Information About your Family *****

Relationship	Age	State of Health	Age and cause of death
Father			
Mother			
Brother 1			
Brother 2			
Brother 3			
Sister 1			
Sister 2			
Sister 3			

Check of your blood relative had any of the following

Disease	Relationship	
Arthritis, Gout		
Asthma. Hay Fever		
Cancer		
Chemical Dependency		
Diabetes		
Heart Disease, Stroke		
High Blood Pressure		
Kidney Disease		
Tuberculosis		
Other		

HEALTH HABITS

***** Check which substance you use and how much *****

	Use	Amount
Caffeine		
Drugs		
Tobacco		
Other		

PREGNANCIES

Year	*Sex*	*Complication If Any*

HOSPITALIZATIONS

Year	Hospital	Reason

OCCUPATIONAL

Check if your work exposes you to the following

Stress		Hazardous Substances	
Heavy Lifting		Other	

Advance Directives Discussed Yes ____ No ____ Copy in chart: Yes ____ No ____

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

Patient's Name:_____ Patient's Signature: _____ Date: _____

Reviewer's Name: _____ Reviewers Signature:_____ Date: _____