

Family History Print the name of each family member below. Follow the line across the page and check those boxes that indicate their present state of health, or their death, or any of the illnesses that they have ever had. If married, print the names of your spouse and children.

	age	health			cause of death	alcoholism	allergies/asthma	anemia	bleeding disorder	cancer/tumor	diabetes	epilepsy	genetic disease	glaucoma	gout	heart problems	high blood pressure	kidney/bladder	nervous breakdown	rheumatism/arthritis	stomach/duodenal ulcer	stroke
		good	poor	died																		
father																						
mother																						
brothers/sisters																						
spouse																						
child																						
child																						
child																						
child																						
all grandparents (check for any affected) →																						
father's relatives (write how many affected in each box) →																						
mother's relatives (write how many affected in each box) →																						

Your History (check for any of *your* illnesses) →

additional illnesses or problems: check the box next to any of the following that you have now or have ever had

<input type="checkbox"/> asthma	<input type="checkbox"/> eczema	<input type="checkbox"/> liver disease	<input type="checkbox"/> pancreatitis	<input type="checkbox"/> thyroid disease
<input type="checkbox"/> blood transfusion	<input type="checkbox"/> emphysema	<input type="checkbox"/> malaria	<input type="checkbox"/> pneumonia	<input type="checkbox"/> venereal disease
<input type="checkbox"/> bronchitis	<input type="checkbox"/> eye disease	<input type="checkbox"/> measles	<input type="checkbox"/> polio	<input type="checkbox"/> yellow jaundice
<input type="checkbox"/> chicken pox	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> other _____
<input type="checkbox"/> depression	<input type="checkbox"/> hernia	<input type="checkbox"/> mumps	<input type="checkbox"/> scarlet fever	_____
<input type="checkbox"/> diverticulosis	<input type="checkbox"/> hyperactivity	<input type="checkbox"/> neuralgia/neuritis	<input type="checkbox"/> tension/anxiety	_____

broken bones _____

injuries _____

Major Illnesses/Operations please list any hospitalizations, serious illnesses or operations; do not include normal pregnancy

year	illness or operation	name of hospital, if applicable	city & state

Tests and Immunizations put a check next to those that you have had and enter the year of the latest test/shot

✓ year	✓ year	✓ year	Other x-rays/tests/shots:	
<input type="checkbox"/> chest x-ray	<input type="checkbox"/> GI series	<input type="checkbox"/> smallpox shot	✓ year	✓ year
<input type="checkbox"/> colon x-ray	<input type="checkbox"/> kidney x-ray	<input type="checkbox"/> tb test	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> electrocardiogram	<input type="checkbox"/> measles shot	<input type="checkbox"/> tetanus shot	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> flu shot	<input type="checkbox"/> mumps shot	<input type="checkbox"/> typhoid shot	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> gallbladder x-ray	<input type="checkbox"/> polio series		<input type="checkbox"/>	<input type="checkbox"/>

Comments

symptoms in the past. Write a "?" if you don't know or don't understand the description or instructions.

general	respiratory	urinary	neurological
<input type="checkbox"/> always hungry	<input type="checkbox"/> chest cold/bronchitis often	<input type="checkbox"/> burning during urination	<input type="checkbox"/> change in handwriting
<input type="checkbox"/> fatigue	<input type="checkbox"/> cough up blood	<input type="checkbox"/> difficulty holding urine	<input type="checkbox"/> convulsions/seizures
<input type="checkbox"/> fever	<input type="checkbox"/> cough up phlegm/mucus	<input type="checkbox"/> difficulty starting urine	<input type="checkbox"/> faintness
<input type="checkbox"/> lost interest in eating	<input type="checkbox"/> coughing spells	<input type="checkbox"/> kidney stones	<input type="checkbox"/> loss of consciousness
<input type="checkbox"/> more thirst lately	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> kidney/urinary infections	<input type="checkbox"/> loss of coordination/balance
<input type="checkbox"/> nail biting	<input type="checkbox"/> toxic inhalant exposure	<input type="checkbox"/> urinate ___ times @ night	<input type="checkbox"/> muscle weakness
<input type="checkbox"/> night sweating	<input type="checkbox"/> (asbestos, dusts, etc)	<input type="checkbox"/> urinate 5-6+ times/day	<input type="checkbox"/> numbness/tingling
<input type="checkbox"/> swelling in armpits/ groin/neck	<input type="checkbox"/> tuberculosis exposure	<input type="checkbox"/> urine brown/black	<input type="checkbox"/> slurred speech
<input type="checkbox"/> tend to be too hot/cold	<input type="checkbox"/> wheezing/gasping breath	<input type="checkbox"/> urine cloudy/bloody	<input type="checkbox"/> sudden loss of vision
<input type="checkbox"/> travel outside USA	cardiovascular	male genital	<input type="checkbox"/> trembling/shaking
<input type="checkbox"/> weight changes	<input type="checkbox"/> blood clots in legs	<input type="checkbox"/> discharge/burning in penis	mood
head & neck	<input type="checkbox"/> can't breathe lying down	<input type="checkbox"/> prostate trouble	<input type="checkbox"/> crying often
<input type="checkbox"/> frequent headaches	<input type="checkbox"/> chest pains	<input type="checkbox"/> sexual difficulties	<input type="checkbox"/> depressed/blue often
<input type="checkbox"/> neck pain	<input type="checkbox"/> dizzy spells	<input type="checkbox"/> swelling/lump on testicle	<input type="checkbox"/> desired/felt counseling need
<input type="checkbox"/> neck lumps/swelling	<input type="checkbox"/> heart murmur	<input type="checkbox"/> wants birth control info	<input type="checkbox"/> difficulty concentrating
<input type="checkbox"/> neck stiffness	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> weak urine stream	<input type="checkbox"/> difficulty expressing affection
eyes	<input type="checkbox"/> irregular heartbeat	female genital	<input type="checkbox"/> difficulty expressing feelings
<input type="checkbox"/> blurry vision	<input type="checkbox"/> leg cramps/aching	<input type="checkbox"/> # Caesarean operations	<input type="checkbox"/> difficulty making decisions
<input type="checkbox"/> discharge/watery eyes	<input type="checkbox"/> numb/cold feet and hands	<input type="checkbox"/> # living children	<input type="checkbox"/> difficulty relaxing
<input type="checkbox"/> double vision	<input type="checkbox"/> palpitations/heart thumping	<input type="checkbox"/> # normal deliveries	<input type="checkbox"/> difficulty remembering
<input type="checkbox"/> eye pains/itching	<input type="checkbox"/> racing heartbeat	<input type="checkbox"/> # of miscarriages	<input type="checkbox"/> hopeless outlook
<input type="checkbox"/> eye trouble	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> # of pregnancies	<input type="checkbox"/> lonely often
<input type="checkbox"/> eyesight worsening	<input type="checkbox"/> shortness of breath at night	<input type="checkbox"/> # therapeutic abortions	<input type="checkbox"/> lose temper often
<input type="checkbox"/> halos around lights	<input type="checkbox"/> swollen feet/ankles	<input type="checkbox"/> bleeding after intercourse	<input type="checkbox"/> nervous around strangers
<input type="checkbox"/> last eye exam: _____	<input type="checkbox"/> varicose veins	<input type="checkbox"/> bleeding between periods	<input type="checkbox"/> sexual concerns
<input type="checkbox"/> light hurts eyes	digestive	<input type="checkbox"/> bloated/irritable before period	<input type="checkbox"/> thinking about ending life
<input type="checkbox"/> wear glasses	<input type="checkbox"/> belching	<input type="checkbox"/> current birth cntrl method: _____	<input type="checkbox"/> troubled frightening dreams
ears	<input type="checkbox"/> black stools	<input type="checkbox"/> DES (diethylstilbestrol) exposure	<input type="checkbox"/> troubled frightening thoughts
<input type="checkbox"/> buzzing/ringing in ears	<input type="checkbox"/> bloated stomach	<input type="checkbox"/> heavy menstrual bleeding	<input type="checkbox"/> worry a lot
<input type="checkbox"/> drainage from ears	<input type="checkbox"/> constipation	<input type="checkbox"/> hormones/birth control pills	
<input type="checkbox"/> earaches	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> hot flashes	
<input type="checkbox"/> hearing loss	<input type="checkbox"/> food allergy/intolerance	<input type="checkbox"/> infertility	
<input type="checkbox"/> motion sickness	<input type="checkbox"/> gallbladder trouble	<input type="checkbox"/> last pap smear - need EXACT date: _____	
mouth	<input type="checkbox"/> grey stools	<input type="checkbox"/> lumps in breasts	
<input type="checkbox"/> bleeding gums	<input type="checkbox"/> hard stools	<input type="checkbox"/> menopause - need YEAR: _____	
<input type="checkbox"/> dental problems	<input type="checkbox"/> heartburn	<input type="checkbox"/> menstrual trouble	
<input type="checkbox"/> grinding teeth	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> nipple discharge	
<input type="checkbox"/> last dental exam _____	<input type="checkbox"/> loose stools/diarrhea	<input type="checkbox"/> pain with intercourse	
<input type="checkbox"/> sore jaws	<input type="checkbox"/> nausea	<input type="checkbox"/> painful periods	
<input type="checkbox"/> sore tongue	<input type="checkbox"/> pain in rectum	<input type="checkbox"/> pelvic surgery - type/date: _____	
<input type="checkbox"/> swelling of gums/jaw	<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> premenstrual tension syndrome	
<input type="checkbox"/> taste changes	<input type="checkbox"/> stomach pains	<input type="checkbox"/> sexual difficulties	
nose & throat	<input type="checkbox"/> ulcers	<input type="checkbox"/> toxemia of pregnancy	comments
<input type="checkbox"/> congested nose	<input type="checkbox"/> vomiting blood	<input type="checkbox"/> vaginal discharge/itching	_____
<input type="checkbox"/> difficulty swallowing	musculoskeletal	<input type="checkbox"/> wants birth control info	_____
<input type="checkbox"/> enlarged tonsils	<input type="checkbox"/> aching joints	skin	_____
<input type="checkbox"/> frequent head colds	<input type="checkbox"/> aching muscles	<input type="checkbox"/> bleed or bruise easily	_____
<input type="checkbox"/> hoarse voice	<input type="checkbox"/> back pains	<input type="checkbox"/> change in wart/mole	_____
<input type="checkbox"/> nosebleeds	<input type="checkbox"/> back stiffness	<input type="checkbox"/> changes in hair/nails	_____
<input type="checkbox"/> runny nose	<input type="checkbox"/> chiropractic/osteopathic treatment	<input type="checkbox"/> difficulty healing cuts	_____
<input type="checkbox"/> sneezing spells	<input type="checkbox"/> handicapped/disabled	<input type="checkbox"/> hives	_____
<input type="checkbox"/> sore throat	<input type="checkbox"/> painful feet	<input type="checkbox"/> itching/burning skin	_____
	<input type="checkbox"/> spinal curvature/scoliosis	<input type="checkbox"/> skin cancer	_____
	<input type="checkbox"/> stiffness in joints	<input type="checkbox"/> skin contact allergies	_____
	<input type="checkbox"/> swollen joints	<input type="checkbox"/> skin problems/rashes	_____