

Patient: _____ **Date:** _____

Have you or any blood relative had: (please circle)

| | | | | | |
|----------------------|------|----------|------------------------------|------|----------|
| Weight Loss | Self | Relative | Allergies, asthma, hay fever | Self | Relative |
| Birth Defects | Self | Relative | Emphysema | Self | Relative |
| Cancer | Self | Relative | Tuberculosis | Self | Relative |
| Psychiatric Problems | Self | Relative | Epilepsy or seizures | Self | Relative |
| Migrane Headaches | Self | Relative | Stroke | Self | Relative |
| Vision Problems | Self | Relative | Glaucoma | Self | Relative |
| Heart Trouble | Self | Relative | Ulcers/Indigestion | Self | Relative |
| Problems Urinating | Self | Relative | Skin Disease | Self | Relative |
| Diabetes | Self | Relative | Anemia | Self | Relative |
| Thyroid Disease | Self | Relative | Bleeding problems | Self | Relative |
| Arthritis | Self | Relative | Osteoporosis | Self | Relative |

Surgical History

| Name of Operation | Date | Complications |
|-------------------|-------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have you ever had a blood transfusion? Y N **Date:** _____

Major Illness or Injury

List any illness or injury requiring hospitalization. Include approximate date.

Medications

| Name of Medication | Strength | How often? |
|--------------------|----------|------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

(may continue on back)

Allergies:

Please list, circle if none: None

Name of Drug/Item: _____