

Name: _____ Age: _____ Date _____

ANY ALLERGIES TO MEDICINES? WHAT EFFECTS?
 1. _____
 2. _____
 3. _____
 4. _____

MEDICINES YOU ARE TAKING (Include over the counter)

Name or Type	Year Begun	Year Stopped	Check Effects		Side Effects
			Helped	No Help	
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					
6. _____					
7. _____					
8. _____					
9. _____					

ANY OPERATIONS? DATE PLACE
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____

ANY TRANSFUSIONS? No Yes When

ANY OTHER HOSPITALIZATIONS? DATE PLACE
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____

CHILDHOOD ILLNESS? (Answer Yes or No)

_____ Mumps	_____ Scarlet or Rheumatic Fever	_____ Heart Murmur
_____ Measles	_____ Nephritis	_____ Mononucleosis
_____ Diphtheria	_____ Kidney Disease	_____ Other
_____ Whooping Cough	_____ Pneumonia	

ANY OTHER SERIOUS ILLNESS OR INJURIES?
 1. _____
 2. _____
 3. _____
 4. _____

FAMILY HISTORY: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide Yes No

	Age if Living?	Cause of Death?	Age at Death	
Father				
Mother				
Brothers & Sisters				
No. Living				
No. Dead				