Name: _____

Age: _____ **Date:** _____

Gessler CLINIC PA
In the Practice of Caring since 1957

Any Allergies to medicines? What effects?
1. _____
2. _____
3. _____
4. _____

Medicines you are taking (include over-the-counter)

Name or type:	Year began	Dosage	# times take per day	Side effects

Any operations?
1. _____ Date: _____ Place: _____
2. _____ Date: _____ Place: _____
3. _____ Date: _____ Place: _____
4. _____ Date: _____ Place: _____

Any transfusions? No _____ Yes _____ Date _____

Any other hospitalizations?
1. _____ Date: _____ Place: _____
2. _____ Date: _____ Place: _____
3. _____ Date: _____ Place: _____
4. _____ Date: _____ Place: _____

Childhood illness? (answer yes or no)

_____ Mumps _____ Whooping cough _____ Kidney disease
_____ Mononucleosis _____ Measles _____ Scarlet or rheumatic fever _____ Heart murmur
_____ Pneumonia _____ Diphtheria _____ Nephritis _____ Other

Any other serious illness or injuries?
1. _____
2. _____
3. _____
4. _____

Family History: (answer yes or no)

_____ Tuberculosis _____ Cancer _____ Heart or kidney disease
_____ Diabetes _____ High Blood Pressure _____ Mental illness or suicide

	Age if living	Cause of death	Age at death
Father			
Mother			

Brothers and sisters:
Number living _____ Number dead _____