



PATIENT HISTORY

Name _____

Date _____

Please fill in the following information on your family history:

<u>Living? Relative</u>	<u>Age or Age at Death</u>	<u>Health Problems or Cause of Death</u>
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_____ Father _____

_____ Mother _____

_____ Sister _____

_____ Brother _____

_____ Grandparents _____

_____ Son _____

_____ Daughter _____

Other Family History? _____

Who do you live with? _____

Marital Status _____

Education _____

Occupation _____

Do you smoke? ____ no ____ yes How many packs a day? _____

Do you drink coffee, tea, or caffeinated beverages? ____ no ____ yes

How much a day? _____

Do you drink alcohol? ____ no ____ yes How much a day? _____

Do you use recreational drugs? ____ no ____ yes

Do you exercise? ____ no ____ yes

Are you sexually active? ____ no ____ yes

Do you eat a special diet? ____ no ____ yes What kind? _____

Do you wear your seatbelt? ____ no ____ yes

Are there firearms in your home? ____ no ____ yes

What are your hobbies? _____

Are your vaccines up to date? ____ no ____ yes ____ do not know

Do you have a living will? ____ no ____ yes

Are you an organ donor? ____ no ____ yes

Have you ever been in the hospital or had surgery? ____ no ____ yes

If yes, list below:

<u>Date</u>	<u>Reason for Hospitalization/Surgery</u>
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