HAVE YOU HAD:	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Head injury w/unconsciousness			Sexually Transmitted Disease			Counseling/Mental Health Treatment		
Asthma			Chicken Pox			Recreational Drug Use		
Recurrent Headaches			Scarlet Fever			Tobacco Use		
Seizure Disorder			Hay Fever			Alcohol Use		
Hearing Loss			Rheumatic Fever			# times per week		
Recurrent Ear Infections			High Cholesterol			Amount per session		
Thyroid Problem			Hepatitis A,B or C			Exercise: # times per week		
Heart Problem/Murmur			Diabetes			Operations/Dates:		
Kidney/Urinary Tract Problems			High Blood Pressure					
Gynecology Problems			Digestive Tract Problem					
Recent Weight Change			Cancer/Tumor/Cyst			Chronic Health Problems:		
Bleeding/Blood Disorder			Eating Disorder					
Tuberculosis								

ALLERGIES or REACTIONS TO MEDICINES:_____

When were your most recent **IMMUNIZATIONS:**

Hepatitis A_____ Hepatitis B____ Influenza (flu shot)_____ Measles_____ Pneumovax (Pneumovax)_____

Rubella_____ Tetanus (Td)_____ Varicella (chicken pox)_____ or Illness_____

When were your most recent **HEALTH MAINTENANCE** screening tests:

Mammogram (year)_____ Normal?_____ PSA (Prostate Cancer Screen)_____ Normal?_____

Pap Smear (year)_____ Normal?_____ Stool Test for Blood_____ Normal?_____

Sigmoidoscopy_____ Normal?_____

HAS ANY FAMILY MEMBER EVER HAD:

(parent, sibling or grandparent)	YES	NO	Relationship:	(parent, sibling or grandparent)	YES	NO	Relationship:
Tuberculosis				Asthma			
Drug/Alcohol Abuse				Thyroid Disease			
Diabetes				Seizure Disorder			
Kidney Disease				Blood Disorder			
Heart Disease				Cancer			
High Blood Pressure				Stroke			
Arthritis				Obesity			
Stomach Disease				Other:			
High Cholesterol							

Family Member	**Health Status** Excellent/Average/Poor	**Age**	**If no longer living, cause of death & age at death**
Father			
Mother			
Brothers			
Sisters			
Spouse/Partner			
Children			