

## FAMILY HISTORY

IF ALIVE                      IF DEAD  
AGE                              AGE and CAUSE

Father		
Mother		
Brother/Sister		
Spouse / Significant Other		
Son(s)/Daughter(s)		

**PLACE A CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE**

**CONDITION                      WHO**

<input type="checkbox"/> Alcohol / Drug Abuse	
<input type="checkbox"/> Allergies / Asthma	
<input type="checkbox"/> Arthritis / Gout	
<input type="checkbox"/> Bleeding Disorder	
<input type="checkbox"/> Cancer (Type)	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Epilepsy/Seizures	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> HIV / AIDS	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Sickle Cell Condition	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Suicide / Depression	
<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Other	

## PERSONAL HISTORY

### QUESTIONS FOR WOMEN ONLY:

#### MENSTRUATION:

Age Periods Began: \_\_\_\_\_  
 How Often: \_\_\_\_\_  
 Last Menstrual Period: \_\_\_\_\_  
 PMS (Pre-Menstrual Syndrome)      \_\_\_ Yes      \_\_\_ No

#### PREGNANCIES:

Total Number: \_\_\_\_\_  
 Full Term: \_\_\_\_\_  
 Premature: \_\_\_\_\_  
 Miscarriages: \_\_\_\_\_  
 Abortions: \_\_\_\_\_  
 Tubal Pregnancies: \_\_\_\_\_  
 Complications: \_\_\_\_\_

### QUESTIONS FOR BOTH MEN & WOMEN:

What kind(s) of Birth Control/Protection do you and/or your partner use?  
 \_\_\_\_\_  
 How would you describe your sexual orientation?  
 \_\_\_\_\_

### DIET, EXERCISE, & HABITS:

Do you follow a special diet? \_\_\_\_\_  
 Weight? Current: \_\_\_\_\_ Desired: \_\_\_\_\_ 1 Year Ago: \_\_\_\_\_  
 What kind of exercise do you do and how often?  
 \_\_\_\_\_

### TOBACCO USE:

Do you smoke?    \_\_\_ No    \_\_\_ Yes    What type? \_\_\_\_\_  
 If yes, how much? \_\_\_\_\_ / per day    \_\_\_\_\_ / per week  
 Have you quit smoking?  
                          \_\_\_ No    \_\_\_ Yes    When \_\_\_\_\_  
 Do you use other tobacco products?  
                          \_\_\_ No    \_\_\_ Yes  
 If yes, what type \_\_\_\_\_ How much \_\_\_\_\_

### ALCOHOL USE:

Do you drink alcohol?    \_\_\_ Yes    \_\_\_ No    How much? \_\_\_\_\_  
 Has anyone ever expressed concerns about your alcohol use?  
    \_\_\_ No    \_\_\_ Yes  
 If yes, please explain: \_\_\_\_\_

## SOCIAL HISTORY

My current status is:    \_\_\_ Married    \_\_\_ Single  
                                  \_\_\_ Widowed    \_\_\_ Separated    \_\_\_ Divorced  
 With whom do you now live? \_\_\_\_\_  
 \_\_\_\_\_  
 Highest education achieved? \_\_\_\_\_  
 Previous jobs? \_\_\_\_\_  
 Exposure to hazardous conditions / substances at work?  
                          \_\_\_ No    \_\_\_ Yes - Type? \_\_\_\_\_  
 Religious preference / beliefs: \_\_\_\_\_  
 Do you have a living will?            \_\_\_ Yes            \_\_\_ No  
 Are you an organ donor?            \_\_\_ Yes            \_\_\_ No