

FAMILY HISTORY: (Continued)

Name: _____

CHILDREN:

Date of Birth: _____

<u>Name</u>	<u>Living</u>	<u>Dead</u>	<u>State of Health or Cause of Death:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Additional information may be placed on bottom of this form, if needed.)

Have any of your blood relatives (aunts, uncles, grandparents, children, parents, etc.) ever had any of the following?

	<u>YES</u>	<u>NO</u>	<u>If yes, what relative?</u>
Diabetes	_____	_____	_____
Cancer (If so, what kind?)	_____	_____	_____
Tuberculosis	_____	_____	_____
High Blood Pressure	_____	_____	_____
Arthritis	_____	_____	_____
Kidney Disease	_____	_____	_____
Epilepsy (Fits)	_____	_____	_____
Heart Disease	_____	_____	_____
Heart Attacks	_____	_____	_____
Lung Diseases (Emphysema)	_____	_____	_____
_____	_____	_____	_____
Strokes	_____	_____	_____
Blood Disease	_____	_____	_____
Thyroid Disease	_____	_____	_____
Hepatitis	_____	_____	_____
Other Infectious Diseases	_____	_____	_____

SOCIAL HISTORY:

Occupation _____

Alcohol: Yes _____ No _____
Quantity per week _____

Tobacco: Yes _____ No _____

Packs of cigarettes per day _____

PERSONAL:

Married _____

Divorced _____

Widowed _____

Live Alone _____

Other _____

EMPLOYMENT STATUS:

Employed _____

Unemployed _____

Retired _____

Occupation _____

DOES YOUR WORK REQUIRE:

Lifting _____

Repetitive Action _____

Sitting Long Periods _____

Machinery Operation _____

Chemical Exposure _____

Framed _____

Other _____

Indoor Plumbing _____

Electricity _____

Heating: (Circle One)

Wood Gas Central Space Heaters

MILITARY SERVICE

If yes, which branch _____

EDUCATION:

High School Completion _____

College _____ Years _____

College Graduate: Yes _____ No _____

Vocational: Yes _____ No _____

TYPE OF HOUSING:

YES NO

Mobile Home _____

Apartment _____

TRANSPORTATION:

YES NO

Auto (car, truck, cycle) _____

Commute with Others _____

Seat Belts _____

Child Restraint Use _____

List any medications taken daily:

1. _____
2. _____
3. _____
4. _____