

MEDICAL HISTORY:

- List any recent health issues: _____

- Surgeries - Type & Year: _____

- Have you ever had any of the following? (please circle)
 Arthritis - Cancer - Diabetes - Gout - Heart Disease - High cholesterol -
 High/Low Blood Pressure - Stroke - Thyroid disease - Ulcer (of the lower extremity)
 Any other disease (please list below):

- Women only: Date of last menstrual period: _____

FAMILY HISTORY:

• Have any of your blood relatives had the following:								Circle relationship:
Cancer	yes	no	Mother	Father	Brother	Sister	Grand Mother	Grand Father
Diabetes	yes	no	Mother	Father	Brother	Sister	Grand Mother	Grand Father
Heart Disease	yes	no	Mother	Father	Brother	Sister	Grand Mother	Grand Father
High Blood Pressure	yes	no	Mother	Father	Brother	Sister	Grand Mother	Grand Father

X _____
Signature of patient or parent if minor **Date**