NAME:	
DATE OF BIRTH:	TODAY'S DATE:

YOUR MEDICAL HISTORY

Please indicate if <u>YOU</u> have a history of the following:

Alcohol Abuse		Growth / Development Disorder	Migraines	
Anemia		Hearing Impairment	Osteoporosis	
Anesthetic Complication		Heart Attack	Prostate Cancer	
Anxiety Disorder		Heart Disease	Rectal Cancer	
Arthritis		Heart Pain/Angina	Reflux/GERD	
Asthma		Hepatitis A	Seizures/Convulsions	
Autoimmune Problems		Hepatitis B	Severe Allergy	

FAMILY MEDICAL HISTORY

Please indicate if <u>YOUR FAMILY</u> has a history of the following: (ONLY include parents, grandparents, siblings, and children)

I am adopted and do not know biological family history						
Family History Unknown	Colon Cancer	Migraines				
Alcohol Abuse	Depression	Osteoporosis				
Anemia	Diabetes	Other Cancer				
Anesthetic Complication	Heart Disease	Rectal Cancer				
Arthritis	High Blood Pressure	Seizures/Convulsions				
Asthma	High Cholesterol	Severe Allergy				
Bladder Problems	Kidney Disease	Stroke/CVA of the Brain				
Bleeding Disease	Leukemia	Thyroid Problems				

Lung/Respiratory Disease