

Family History

	Age	State Of Health	Age at Death	Cause of Death	Have any of your relatives had any of the following:			
					Yes	No	Relationship	
Father					Allergy, asthma, hay fever			
Mother					Cancer			
Brothers					Diabetes			
					Heart Disease			
					High blood pressure			
Sisters					Kidney disease			
					Neuro-muscular disorder			
Spouse					Tuberculosis			
Children					Other			

Personal History

Do you have, or have you ever had: (check all that apply) Explain YES answers below.

Head & Nervous System	Neck	Urinary	Allergy
1 <input type="checkbox"/> Frequent headaches	23 <input type="checkbox"/> Thyroid disease	46 <input type="checkbox"/> Frequent urination	70 <input type="checkbox"/> Hay fever
2 <input type="checkbox"/> Migraine	24 <input type="checkbox"/> Enlarged lymph nodes	47 <input type="checkbox"/> Painful urination	71 <input type="checkbox"/> Hives/rashes
3 <input type="checkbox"/> Severe head injury/concussion	Heart	48 <input type="checkbox"/> Blood in urine	72 <input type="checkbox"/> Food allergy
4 <input type="checkbox"/> Seizures/convulsions	25 <input type="checkbox"/> High blood pressure	49 <input type="checkbox"/> Protein in urine	73 <input type="checkbox"/> Insect bites/bee stings
5 <input type="checkbox"/> Dizzy spells/fainting	26 <input type="checkbox"/> Heart murmur/click	50 <input type="checkbox"/> Sugar in urine	74 <input type="checkbox"/> Drug allergy (please list below)
6 <input type="checkbox"/> Insomnia	27 <input type="checkbox"/> Heart trouble	51 <input type="checkbox"/> Bladder infection	Other
7 <input type="checkbox"/> Recurrent anxiety	28 <input type="checkbox"/> Palpitations	52 <input type="checkbox"/> Kidney infection/disease	75 <input type="checkbox"/> Tumor/malignancy
8 <input type="checkbox"/> Recurrent depression	29 <input type="checkbox"/> Shortness of breath	53 <input type="checkbox"/> Kidney stone	76 <input type="checkbox"/> Sexually transmitted disease
Eyes, Ears, Nose, Throat	30 <input type="checkbox"/> Chest pain	Bones, Joints	77 <input type="checkbox"/> Anemia
9 <input type="checkbox"/> Wear glasses/contact lenses	Lungs	54 <input type="checkbox"/> Fractures or dislocations	78 <input type="checkbox"/> High cholesterol
10 <input type="checkbox"/> Blindness	31 <input type="checkbox"/> Asthma	55 <input type="checkbox"/> Painful or trick joints	79 <input type="checkbox"/> Diabetes
11 <input type="checkbox"/> Injury/disease	32 <input type="checkbox"/> Bronchitis	56 <input type="checkbox"/> Deformity	80 <input type="checkbox"/> Anorexia/bulemia
12 <input type="checkbox"/> Double vision	33 <input type="checkbox"/> Pneumothorax	57 <input type="checkbox"/> Paralysis or polio	81 <input type="checkbox"/> Following any special diet
13 <input type="checkbox"/> Deafness/hearing aid	34 <input type="checkbox"/> Pneumonia	58 <input type="checkbox"/> Arthritis	Special Needs
14 <input type="checkbox"/> Perforated eardrum	35 <input type="checkbox"/> Pleurisy	59 <input type="checkbox"/> Back problems	82 <input type="checkbox"/> Regular medical care
15 <input type="checkbox"/> Repeated ear infections	Digestive	60 <input type="checkbox"/> Knee or ankle problem	83 <input type="checkbox"/> Limited physical activity
16 <input type="checkbox"/> Sinus trouble	36 <input type="checkbox"/> Ulcers	Infectious Diseases	Past Illnesses
17 <input type="checkbox"/> Repeated nose bleeds	37 <input type="checkbox"/> Chronic abdominal pain	61 <input type="checkbox"/> Mononucleosis	84 <input type="checkbox"/> Hospitalizations
18 <input type="checkbox"/> Frequent sore throat	38 <input type="checkbox"/> Diarrhea, chronic/recurrent	62 <input type="checkbox"/> Measles (Rubeola)	85 <input type="checkbox"/> Operations
19 <input type="checkbox"/> Strep throat	39 <input type="checkbox"/> Colitis, Ilietis	63 <input type="checkbox"/> Mumps	86 <input type="checkbox"/> Serious illnesses
20 <input type="checkbox"/> Tonsils/adenoids removed	40 <input type="checkbox"/> Gall stones	64 <input type="checkbox"/> German measles (Rubella)	87 <input type="checkbox"/> Serious injuries/accidents
Dental	41 <input type="checkbox"/> Hepatitis/jaundice	65 <input type="checkbox"/> Chicken Pox (Varicella)	88 <input type="checkbox"/> Emotional problems
21 <input type="checkbox"/> Poor teeth/tooth aches	42 <input type="checkbox"/> Appendectomy	66 <input type="checkbox"/> Rheumatic fever	88 <input type="checkbox"/> Psychological treatment
22 <input type="checkbox"/> Bleeding gums/gum disease	43 <input type="checkbox"/> Hemorrhoids	67 <input type="checkbox"/> Malaria	89 <input type="checkbox"/> Psychiatric treatment
	44 <input type="checkbox"/> Irritable bowel	68 <input type="checkbox"/> Meningitis	
	45 <input type="checkbox"/> Sudden weight change	69 <input type="checkbox"/> TB or positive skin test	

Identify YES answers by number. Provide details, including dates:
