

**PATIENT/FAMILY HISTORY**

List all serious illnesses (cancer, diabetes, tuberculosis, heart disease):

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List any surgical procedures/injuries and when they occurred:

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Please circle any of the following that pertain to you:

Smoke	Indigestion	Pneumonia	COPD
History of Smoking	Diverticular Disease	Emphysema	Asthma
Drink	Irregular Heart Beat	Anxiety	CAD
Stroke	Heart Attack	Depression	CHF
Seizures	High Blood Pressure	Bi-Polar	Hypothyroidism
Diabetes	Elevated Cholesterol	Endometriosis	Insomnia
Thyroid Issues	Arthritis	Blood Thinners	Edema
Ulcer	Stones	Clotting Disorder	Cataracts
Reflux	Sleep Apnea	Sexually Transmitted Disease	HIV

Do your parents/siblings/grandparents have any of the following health problems:

Diabetes – Who: \_\_\_\_\_

Cancer – Who: \_\_\_\_\_ Type: \_\_\_\_\_

Prostate Cancer: \_\_\_\_\_

Hypertension: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Stone Disease: \_\_\_\_\_

Kidney Disease: \_\_\_\_\_

Stroke – Who: \_\_\_\_\_

Emphysema – Who: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_