

PATIENT'S NAME _____ BIRTH DATE _____ SEX _____ S.M.W.D. _____

ADDRESS _____ TEL. NO. _____

INSURANCE _____ REFERRED BY _____ OCCUPATION _____

INSTRUCTIONS: PUT IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

FAMILY HISTORY

	FATHER	MOTHER	BROTHER				SISTER				SPOUSE	CHILDREN					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
AGE (IF LIVING)																	
HEALTH (G) Good (B) BAD																	
CANCER																	
TUBERCULOSIS																	
DIABETES																	
HEART TROUBLE																	
HIGH BLOOD PRESSURE																	
STROKE																	
EPILEPSY																	
NERVOUS BREAKDOWN																	
ASTHMA, HIVES, HAY FEVER																	
BLOOD DISEASE																	
AGE (AT DEATH)																	
CAUSE OF DEATH																	

PERSONAL HISTORY

HAVE YOU EVER HAD . . .	NO	YES	HAVE YOU EVER HAD . . .	NO	YES	HAVE YOU EVER HAD . . .	NO	YES
<input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> SCARLATINA			<input type="checkbox"/> GONORRHEA <input type="checkbox"/> SYPHILIS			ANY <input type="checkbox"/> BROKEN <input type="checkbox"/> CRACKED BONES		
DIPHTHERIA			ANEMIA			RECURRENT DISLOCATIONS		
SMALLPOX			JAUNDICE			<input type="checkbox"/> CONCUSSION <input type="checkbox"/> HEAD INJURY		
PNEUMONIA			EPILEPSY			EVER BEEN KNOCKED UNCONSCIOUS		
PLURISY			MIGRAINE HEADACHES			<input type="checkbox"/> FOOD <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DRUG POISONING		
UNDULANT FEVER			TUBERCULOSIS			EXPLAIN		
<input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> HEART DISEASE			DIABETES					
ST. VITUS DANCE			CANCER					
<input type="checkbox"/> ARTHRITIS <input type="checkbox"/> RHEUMATISM			<input type="checkbox"/> HIGH <input type="checkbox"/> LOW BLOOD PRESSURE			ANY OTHER DISEASE		
ANY <input type="checkbox"/> BONE <input type="checkbox"/> JOINT DISEASE			NERVOUS BREAKDOWN			EXPLAIN		
<input type="checkbox"/> NEURITIS <input type="checkbox"/> NEURALGIA			<input type="checkbox"/> HAY FEVER <input type="checkbox"/> ASTHMA					
<input type="checkbox"/> BURSTITIS <input type="checkbox"/> SCIATICA <input type="checkbox"/> LUMBAGO			<input type="checkbox"/> HIVES <input type="checkbox"/> ECZEMA					
<input type="checkbox"/> POLIO <input type="checkbox"/> MENINGITIS			FREQUENT <input type="checkbox"/> COLDS <input type="checkbox"/> SORE THROAT			WEIGHT: NOW ONE YR. AGO		
BRIGHT'S DISEASE			FREQUENT <input type="checkbox"/> INFECTIONS <input type="checkbox"/> BOILS			MAXIMUM WHEN		

ALLERGIES

ARE YOU ALLERGIC TO . . .	NO	YES	ARE YOU ALLERGIC TO . . .	NO	YES	ARE YOU ALLERGIC TO . . .	NO	YES
<input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
<input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> MORPHINE			EXPLAIN			EXPLAIN		
<input type="checkbox"/> MYCINS <input type="checkbox"/> OTHER ANTIBIOTICS								
<input type="checkbox"/> TETANUS <input type="checkbox"/> ANTITOXIN <input type="checkbox"/> SERUMS			ADHESIVE TAPE			<input type="checkbox"/> NAIL POLISH <input type="checkbox"/> OTHER COSMETICS		

SURGERY

HAVE YOU HAD REMOVED . . .	NO	YES	HAVE YOU HAD REMOVED . . .	NO	YES	HAVE YOU . . .	NO	YES
TONSILS			<input type="checkbox"/> OVARY <input type="checkbox"/> OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			HAD ANY OTHER OPERATIONS		
GALL BLADDER			EVER HAVE A TRANSFUSION			BEEN HOSPITALIZED FOR ANY ILLNESS		
UTERUS			<input type="checkbox"/> BLOOD <input type="checkbox"/> PLASMA			EXPLAIN		

X-RAYS

EVER HAVE X-RAYS OF . . .	NO	YES	DATE	DISEASE PRESENT
CHEST				
<input type="checkbox"/> STOMACH <input type="checkbox"/> COLON				
GALL BLADDER				
EXTREMITIES				
BACK				
OTHER				