FAMILY HISTORY

North Cypress Internal Medicine & Wellness

Patient's Name:

Relation	Age	State of Health	Health problems (if decease, age, and cause)
Mother			
Father			
Brothers			
Sisters			

Have any of your blood relatives had any of the following: (if yes check and list relationship to you)

- ❐ Cancer (type:_______________)
- ❐ Diabetes
- ❐ Heart attack
- ❐ Heart Disease
- ❐ Stroke
- ❐ High blood pressure
- ❐ Kidney disease
- ❐ Tuberculosis
- ❐ Arthritis or gout
- ❐ Asthma or hay fever
- ❐ Chemical dependency

HEALTH HABITS

		How much per day or week?	How many yrs?
Tobacco	❐ Now ❐ Quit		
Alcohol	❐ Now ❐ Past		
Drugs	❐ Now ❐ Past		
Other substances			
Exercise Type?			

Immunizations

Date of last tetanus shot?____________

Date of last flu / influenza shot? _________

Have you ever had a pneumococcal vaccine (pneumovax or "pneumonia") shot? ❐ Y ❐ N

Date? _________________

Hepatitis vaccine? ❐ Y ❐ N

Other?___________________

Describe Diet:

Hospitalizations

Year	Hospital	Reason for hospitalization and outcome

Serious illness / injuries / surgeries	Date	Outcome

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature of patient ______________________ Date ____________

Reviewed By ______________________ Date ____________