This information helps to establish a data base to aid in your care. Your cooperation is needed and appreciated...

Last _____ First _____ Middle Initial _____ ❒ Male ❒ Female _____ Date of Birth

❒ Married ❒ Single ❒ Divorced ❒ Seperated ❒ Widowed OCCUPATION: _____

List all persons who live in your household:

Name:	Relation:	Age:	Leave Blank:

HAVE YOU OR A BLOOD RELATIVE HAD: (Check if YES/Give Relationship)

	You:	Other/Relationship	Leave Blank:
Diabetes			
Cancer			
High Blood Pressure			
Heart Trouble			
Liver Problems or Hepatitis			
Asthma, Hay Fever			
Thyroid Problem			
Stomach or Bowel Problems			
Stroke			
Lung Problems			
Kidney, Bladder or Urinary Problem			
Arthritis			
Tuberculosis			
Glaucoma			
Psychiatric Illness			
Alcoholism			
Neurologic Diseases			
Migraines			
Skin Diseases			
Anemia			
Seizures/Fits			
Birth Defects			

FAMILY TREE
LEAVE BLANK

MATERNAL PATERNAL

OPERATIONS: None: ❒

	What Kind:	Year:
1		
2		
3		
4		
5		
6		

HOSPITALIZATIONS: (Other than Operations & Childbirth)

None: ❒

	Why:	Year:
1		
2		
3		
4		
5		
6		

Other Physicians Seen In The Richmond Area:

ALLERGIES: (Medicines or Others) None: ❒

List Medicines Taken On A Regular Basis:

HABITS, ETC:

Alcohol None: ❒

Liquor: Drinks per: _____ _____ yrs

Beer: Beers per: _____ _____ yrs

Wine: Drinks per:: _____ _____ yrs

Tobacco None: ❒

❒ Cigarettes ❒ Cigars ❒ Pipes

_____ packs per day for _____ yrs

IMMUNIZATIONS:

Date of last Tetanus shot: _____

Other: _____

Do you have personal, sexual or emotional problems ?

Yes: ❒ No: ❒

Other information that may aid in your care: