IDENTIFICATION DATA

Fill in the following information. PLEASE PRINT.

Date _____ # _____

Name _____ Date of birth _____ ____ Male ____ Female

Address _____ ___ Married ___Separated ___ Divorced ___ Widowed ___ Single

_____ Education: ____ years Elementary ____ years High School

Home telephone _____ (area code) ____ years College, Technical, Business, etc.

Business telephone _____ (area code) Occupation _____

FAMILY HISTORY:

For your family members below, follow the line across the page and mark an X in those boxes which indicate their present state of health (good), (poor), or their death (write in the cause), and any of the illnesses that they have ever had.

Print the names of your relatives living or dead in the spaces below.

	Health: Good	Health: Poor	Died	Cause of death	Allergies or asthma	Anemia	Bleeding tendencies	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Gout	High blood pressure	Kidney or bladder trouble	Stomach/duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	Heart trouble
Father:																		
Mother:																		
Brothers or Sisters:																		
Spouse:																		
Children:																		
Grandparents: (Mark an X for illnesses only)																		

YOUR HEALTH HISTORY

(begin here with illnesses ⟶)

Additional Illnesses: Mark an X in the box next to any of the following illnesses you now or ever have had.

☐ eczema	☐ hemorrhoids	☐ thyroid disease	☐ mumps	☐ venereal disease
☐ hives or rashes	☐ hernia	☐ chicken pox	☐ nervous exhaustion	☐ yellow jaundice
☐ bronchitis	☐ liver disease	☐ German measles	☐ pneumonia	☐ other _____
☐ diverticulosis	☐ malaria	☐ scarlet fever	☐ polio	☐ _____
☐ emphysema	☐ neuralgia or neuritis	☐ measles	☐ kidney trouble	☐ _____
☐ eye infections	☐ pancreatitis	☐ mononucleosis	☐ rheumatic fever	☐ _____

Have you ever been turned down for life insurance, military service or employment because of health problems? ..... ____ Yes ____ No

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. Check this box ☐ if you have had more than three such hospitalizations.

(Do not include normal pregnancies)	Year	Operation or Illness	Name of Hospital	City and State
1st hospitalization				
2nd hospitalization				
3rd hospitalization				

Tests and Immunizations: Mark an X next to those which you have had. Enter the year when you last were given the test or "shots."

Year		Year	
☐ 19___	chest x-ray	☐ 19___	smallpox "shots"
☐ 19___	kidney x-ray	☐ 19___	tetanus "shots"
☐ 19___	G.I. series	☐ 19___	polio series
☐ 19___	colon x-ray	☐ 19___	typhoid "shots"
☐ 19___	gallbladder x-ray	☐ 19___	flu injections
☐ 19___	electrocardiogram	☐ 19___	mumps "shots"
☐ 19___	TB test	☐ 19___	measles "shots"
☐ 19___	other x-rays	☐ 19___	other _____

Medicines: Mark an X in the box next to any medicines that you are now taking or that you are allergic to.

taking	allergic to:		taking	allergic to:	
☐	☐	aspirin	☐	☐	diet pills
☐	☐	penicillin	☐	☐	antacids
☐	☐	sulfa	☐	☐	laxatives
☐	☐	codeine	☐	☐	cold tablets
☐	☐	antibiotics	☐	☐	_____
☐	☐	sedatives	☐	☐	_____
☐	☐	stimulants	☐	☐	_____
☐	☐	Demerol	☐	☐	_____

Signature (if filled out by other than patient): _____

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