HEALTH HISTORY
SELF, YOUR PARENTS, AND OTHER RELATIVES

Indicate by checking the appropriate box if you or any relatives (for example, your parents, brothers, sisters, aunts, uncles, grandparents, children, etc.), have or have had any of the medical conditions listed below. If yes, please indicate that person's relationship to you and complete the COMMENTS section. If a medical condition resulted in death of a family member, please indicate and give the person's approximate age at the time of death in the COMMENTS section.

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
CONGENITAL IMPAIRMENTS Club foot or any orthopedic problem (i.e., flat footed, etc.)			
Harelip (cleft lip) or cleft palate			
Downs Syndrome			
Other chromosome abnormality			
Hydrocephalus			
Muscular Dystrophy			Areas affected and age at onset
Dwarfism			
Spina Bifida			
Medical Condition	**Yes, No, or Unknown**	**Relationship To You**	**Comments**
Congenital heart defect			
Tay-Sachs Disease			
ALLERGIES Eczema or other skin condition			Treatment or medication received
Hay fever			
Medication allergy			To what medication?
Food allergy			To what foods?
EYE, DENTAL, EAR AND DEVELOPMENTAL DISORDERS			

Blindness, Glaucoma, color blindness, or other visual problems			
Corrective glasses or contact lenses			At what age were prescription lenses necessary?
Farsighted or nearsighted			
Astigmatism (inability to focus)			
Strabismus (cross-eye)			
Other (explain)			
Braces on teeth or other orthodontic work			What orthodontic work and for how long?
Deafness or other ear problems			Special education? Age at onset
Speech problems			Special education? Age at onset
Medical Condition	**Yes, No, or Unknown**	**Relationship To You**	**Comments**
Learning disability			Any diagnosis/hospitalization?
Retardation - mental or physical			Any diagnosis/hospitalization?
CIRCULATORY DISORDERS Hemophilia			
Sickle Cell Anemia or trait			
Hypertension (high blood pressure)			Age at onset, what treatment? Hospitalization?
Stroke			Age, treatment?
Heart Attack (coronary)			Age, treatment?
Arthritis			What kind? Age at onset and areas affected
Hepatitis			What type? Age at onset and

			treatment
Kidney disease			Age at onset and treatment
HORMONAL DISORDERS Diabetes			Age at onset and treatment
Medical Condition	**Yes, No, or Unknown**	**Relationship To You**	**Comments**
Thyroid Disorder			Age at onset and treatment
Obesity (overweight)			Age at onset and treatment
RESPIRATORY DISORDERS Asthma			Treatment
Tuberculosis			What kind and age at onset
Emphysema			Age at onset
MENTAL AND BEHAVIORAL DISORDERS Diagnosed Schizophrenia			Age at onset and treatment. Hospitalization?
Diagnosed Manic Depressive			Treatment
Other mental illness			Describe, using additional paper if necessary
Alcoholism or heavy drinking			Treatment/hospitalization?
Drug usage			Kind, amount and when taken?
LYMPHATIC DISORDERS Cancer			Kind, age at onset, areas affected
Tumors			Kind, age at onset, areas affected

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Cystic Fibrosis			Age at onset, areas affected
Hodgkin's Disease			Age at onset, areas affected
NERVOUS SYSTEM DISORDERS Multiple Sclerosis			Age at onset, areas affected
Huntington's Disease			Age at onset, areas affected
Cerebral Palsy			Age at onset
Seizures or convulsions			Frequency, age at onset, what treatment
Epilepsy			Frequency, age at onset, what treatment
INFECTION, HOSPITALIZATION Repeated attacks of fever with known Infection			Diagnosis
Repeated severe infection necessitating hospitalization			Diagnosis
Hospitalization, operation or injury			When and for what
OTHER MEDICAL OR HEALTH PROBLEMS			Describe

_____ _____

Signature Date