

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