

What surgical operations have you had (please give dates):

	No	Yes	Date		No	Yes	Date
Tonsils				Have you ever had a serious accident or injury?			
Appendix							
Hemorrhoids				Please describe and give dates			
Female Operations							
Other Operations (Please List)							
				Broken bones? (Which)			
				Concussion or Head Injury			

Please list any medications you are sensitive or allergic to: or which have caused a rash:

Other than as local skin or eye treatment or injection into a joint, have you ever been given any CORTISONE or ACTH? No Yes

If so, when? Have you ever had a blood transfusion? No Yes If so, when?

Immunizations: (Please give date of last booster) Tetanus Influenza Pneumovax

Residence or travel outside USA (Places and dates)

Have you ever received any form of penicillin? No Yes

If so, were there any unfavorable reactions? No Yes

If yes, please describe

II. MARITAL HISTORY:

Present marriage _____ Years _____ Previous marriages and duration _____

Health of spouse _____

Children: (If adopted, so state) No. living _____ Sex, Ages, and Health _____

_____ No. dead _____ Sex, Ages, and Causes _____

III. FAMILY HISTORY: (Blood relatives only)

	Age - or Age at Death	Present Health or Cause at Death
Father:		
Mother:		
Brothers: No. living		
No. dead		
Sisters: No. living		
No. dead		

Have any of your blood relatives ever had: (If yes, state relationship)

Cancer Type _____ Migraine (Sick headache) _____ Bleeding tendency _____

Heart Trouble _____ Diabetes _____ Nervous or Mental Disease _____

High Blood Pressure _____ Kidney Disease _____ Stroke _____

IV. SOCIAL HISTORY:

Do you use tobacco now? _____ In the past? _____ For how long? _____ Type and amount daily _____

Do you use alcoholic beverages now? _____ In the past? _____ Type and amount daily or weekly _____