(ADULT)

Name:_____

DOB: _____

Current/recurrent illnesses and complaints

Illness/Complaint	Medications/Treatments	Reactions

Allergies, sensitivities, exposures, intolerances (foods, drugs, chemicals, plants, animals, weather, climate, etc.)

Substance	Reactions

Major Illnesses and Injuries (Past)

Age	Illness or Injury	Treatment and Complications

OVER ➔

Hospitalizations/Surgery

Age	Illness or Condition	Treatment and Complications

Pregnancy, miscarriages, abortions, births, nursing, menstrual history

Age	Events of Pregnancy	Labor/Delivery	Post-Partum

Family History: Serious or unusual diseases, including (but not limited to) TB, Cancer, Epilepsy, Alcoholism, Sexually transmitted diseases, Mental Illness, etc.

Mother	Grandmother	Father	Grandmother
	Grandfather		Grandfather

Mother's Family	Father's Family

Sisters	Brothers	Children