

Family History

Blood Relatives

This page refer to your mother, father, sister, brother, aunt, uncle, or grandparent. If you select yes, to any of the following, please indicate the *relative* in the blank provided.

	<u>Select Yes or No</u>		<u>If yes, name who</u>
Allergies	Yes	No	_____
Anemia	Yes	No	_____
Alcoholism	Yes	No	_____
Arthritis	Yes	No	_____
Birth Defects	Yes	No	_____
Bleeding disorders	Yes	No	_____
Cancer	Yes	No	_____
Emphysema	Yes	No	_____
Epilepsy (Seizure disorder)	Yes	No	_____
Diabetes	Yes	No	_____
Family history of Anesthesia Complications	Yes	No	_____
History of Sudden Death	Yes	No	_____
Kidney disease	Yes	No	_____
Family history of Neurologic disease	Yes	No	_____
Heart disease	Yes	No	_____
Liver disease	Yes	No	_____
Psychiatric disease (Mental Illness)	Yes	No	_____
Stroke	Yes	No	_____
Tuberculosis	Yes	No	_____
Thyroid disease	Yes	No	_____

Patient Name: _____ Date of Birth: _____