SKAGIT REGIONAL HEALTH
SKAGIT VALLEY HOSPITAL
SKAGIT REGIONAL CLINICS
CASCADE SKAGIT HEALTH ALLIANCE

FAMILY AND PERSONAL HEALTH HISTORY
SRCCC

Note: Please complete all information on this record. All information is treated in confidence and will not be release unless you grant permission.

NAME:	AGE:	BIRTHDATE:	TODAY'S DATE:

FAMILY RECORD Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.	FATHER	MOTHER	BROTHER		SISTER		SON	DAUGHTER
Alcoholism								
Allergies								
Anemia								
Arthritis								
Asthma								
Birth Defects								
Bleeding Tendency								
Cancer								
Colitis								
Congenital Heart								
Diabetes								
Emphysema								
Epilepsy								
Glaucoma								
Goiter								
Hay Fever								
Heart Attack								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Leukemia								
Liver Disease								
Mental Illness								
Migraine								
Nervous Breakdown								
Obesity								
Rheumatism								
Rheumatic Fever								
Sickle-Cell Anemia								
Stomach Ulcer								
Stroke								
Suicide								
Tuberculosis								
Alive								
Deceased								

SURGERIES:

Date:

Date:

Date:

Date:

MEDICATIONS:

ALLERGIES:

FAMILY AND PERSONAL HEALTH HISTORY - SRCCC

S3601
08/01/2012

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PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either **Yes** or **No** and give approximate date if **Past.**	**No**	**Yes** Now	**Yes** Past	**Date** (if Past)
Asthma				
Abnormal Chest X-Ray				
Abnormal Electrocardiogram				
Angina				
Anemia (Type:)				
Arthritis				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Diabetes				
Emphysema				
Enlarged Heart				
Heart Murmur as Adult				
Heart Attack				
High Blood Pressure				
Hepatitis				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Phlebitis				
Rheumatic Fever				
Stroke				
Stomach or Duodenal Ulcer				
Serious Depression				
Serious Emotional Problems				
Tuberculosis				
Thyroid Trouble				

Check (✓) all items either **Yes** or **No** and give approximate date if **Past.**	**No**	**Yes** Now	**Yes** Past	**Date** (if Past)
Man				
Prostate Problems				
Woman				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease*				
Other Gynecological Problems*				
Still Menstruating				

Age Periods Started: _____
Age Periods Stopped: _____
Why Periods Stopped: _____
Number of Pregnancies: _____
Number of Children: _____
Number of Miscarriages: _____

*Explain:

Man and Woman describe any unlisted illnesses you have had:

Doctor's Use Only - Summary

FAMILY AND PERSONAL HEALTH HISTORY - SRCCC

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