MEDICAL HISTORY
(Make a copy for each person)

Date:

Name:
Birthdate:
Blood type:

I have/have had:

	Chicken pox		Cancer
	German measles		Kind: Date:
	Measles		
	Mumps		Kind: Date:
	Whooping cough		
	Shingles		Surgery
	Pneumonia		Kind: Date:
	Asthma		
	Arthritis		Kind: Date:
	Diabetes type		
	Skin problems:		Mental illness:
	Heart problems:		Other diseases:
	Allergies:		Chronic health problems:

Father	Mother
Cancer (kind):	Cancer (kind):
Heart problems:	Heart problems:
High blood pressure	High blood pressure
Diabetes type	Diabetes type
Mental illness:	Mental illness:
Asthma	Asthma
Arthritis	Arthritis
Skin problems:	Skin problems:
Allergies:	Allergies:
Surgeries:	Surgeries:
Chronic health problems:	Chronic health problems:
Other:	Other:

Paternal Grandfather	Paternal Grandmother
Cancer (kind):	Cancer (kind):
Heart problems:	Heart problems:
Diabetes type	Diabetes type
Mental illness:	Mental illness:
Other:	Other:

Maternal Grandfather	Maternal Grandmother
Cancer (kind):	Cancer (kind):
Heart problems:	Heart problems:
Diabetes type	Diabetes type
Mental illness:	Mental illness:
Other:	Other: