HOSPITALIZATIONS		
Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ No ☐ Yes

If yes, please give approximate dates _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS

Check (✓) which substances you use and describe how much you use.

☐ Caffeine _____

☐ Tobacco _____

☐ Drugs _____

☐ Other _____

_____

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

☐ Stress ☐ Hazardous Substances ☐ Heavy lifting

☐ Other _____

_____

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____