Barnabas Health

Name: _____ Date of Birth: __/__/____

HEALTH HABITS: check which apply (if current please indicate amount)

	Never	Past	Current	Amount
Tobacco Use				
Alcohol Use				
Seat Belt Use				
Exercise				

HEALTH MAINTENANCE: Have you had any of the following? (if YES indicate when)

	NO	YES	DATE
Mammography (Females age 40-69)			
Pap Smear (Females age 18-75)			
Colonoscopy (age 50-75)			
Bone Density (age >65)			
Last Menstrual Period (females)			
Gynecologist (females)	**NAME**		

FAMILY HISTORY

Relation	√ If Alive	Age at Death	Medical conditions/ Cause of Death
Mother			
Father			
Brothers			
Sisters			
Children			
Grandparents			

DO ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING?

Disease		Relationship to You
Anemia		
Arthritis		
Asthma		
Blood Clots		
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Stroke		
Other:		