HILL PARK MEDICAL CENTER
HEALTH HISTORY

Name: ______________________________ Date: ______________

Please list your health problems in order of importance to you

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

FAMILY HISTORY

	Mother	Father	Sisters	Brothers	Children
Age (if living)					
Health (Good, fair, poor)					
Age of Death (if deceased)					

Check all that apply:	Mother	Father	Sisters	Brothers	Children
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness					
Asthma					
Eczema					
Hayfever					
Anemia					
Kidney Disease					
Tuberculosis					
Thyroid Disease					