Wetaskiwin Family Medical Practice

CHART NUMBER: ____________________

NAME: ____________________________

PERSONAL HISTORY

Have you ever been diagnosed with? (please circle)

High Blood Pressure	High Cholesterol	Asthma	Kidney Conditions
Diabetes	Epilepsy/Seizure Disorder	Heart Disease	Stroke/TIA
COPD	Mental Health: ______________________		

Cancer: ____

Other: ____

Tobacco Use? ____ Number of packs per day___ Number of years smoked___ Quit?____

SURGICAL HISTORY

1. ______________________________________ Year: __________
2. ______________________________________ Year: __________
3. ______________________________________ Year: __________
4. ______________________________________ Year: __________
5. ______________________________________ Year: __________

FAMILY HISTORY

Do you have a parent, brother or sister with a history of the following?
(please circle and also note if mother, father, brother or sister)

Hypertension	High Cholesterol	Asthma
Diabetes	Seizure Disorder	Heart Disease
COPD	Mental Health: ____________________	

Cancer: ____

Other: ____