2121 Whitesburg Dr, Suite C ♦ Huntsville, AL 35801 ♦ www.blossomwoodmedical.com ♦
phone: 883-0107 ♦ fax: 883-0207

Family History (Fill in as much as you can.)

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if any BLOOD relative have ever had the following (check all that apply, and specify whom).

- ☐ Asthma ____________________
- ☐ Gout ____________________
- ☐ Arthritis ____________________
- ☐ Hay Fever ____________________
- ☐ Cancer ____________________
- ☐ Chemical Dependence ____________________
- ☐ Diabetes ____________________
- ☐ Heart Disease ____________________
- ☐ Strokes ____________________
- ☐ Hypertension ____________________
- ☐ Kidney Disease ____________________
- ☐ Tuberculosis ____________________
- ☐ Thyroid Disease ____________________
- ☐ Other ____________________

Personal Medical History (Circle 'Y' for yes or 'N' for no.)

1. Do you regard your work as stressful? Y N
2. Do you regard your homelife as tense? Y N
3. Are you a perfectionist? Y N
4. Do you have trouble sleeping? Y N
5. Do you "blow up" often? Y N
6. Do you become depressed easily? Y N
7. Are you frequently irritable? Y N
8. Have you ever had a blood transfusion? Y N
   If yes, when? ________________________________
9. Do you exercise at all? Y N
   If yes, how often? ____________________________
   What kind? ___________________________________
10. Have you ever been treated by a pain management physician? Y N
    If yes, whom? ________________________________

Surgeries (Please list what kind, date, and surgeon.)

What?	When?	By Whom?

Occupational Concerns (Check all that your work exposes you to.)

- ☐ Stress
- ☐ Hazardous Substances
- ☐ Heavy Lifting
- ☐ Other
  Please specify:
  ____
  ____

What is your occupation?
____

Heath Habits (Please check all that apply. Note how much you use, and the approximate beginning date of each substance.)

- ☐ Caffeine
  How much? ____________
  Begin date: ____________
- ☐ Tobacco
  How much? ____________
  Begin Date: ____________
- ☐ Alcohol
  How much? ____________
  Begin date? ____________
- ☐ Other: (please specify) ________________
  How much? ____________________
  Begin date: ____________________

I certify that the above information is correct to the best of my knowledge. I will not hold any member of the Blossomwood Medical staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ____________________________

Signature **Date**

Blossomwood
MEDICAL