12. Where you in the military? yes no

If yes, what did you do in the military?_____

_____

_____

_____

Family Health History

1. In the FAMILY MEMBER column, across from the disease name, write which family member, if any, had the disease.

DISEASE	FAMILY MEMBER
Cancer	
Lymphoma	
Sickle Cell Disease or Trait	
Immune Disease	
Leukemia	
Anemia	

2. Please fill in the following information about family health:

Relative	Alive?	Age at death?	Cause of death?
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Personal Health History

Birth Date____/____/____ Age_____ Sex_____ Height_____ Weight_____

Please circle your answer.

1. Do you smoke any tobacco products? yes no

2. Have you ever had any kind of surgery or operation? yes no

If yes, what type of surgery:_____

_____

_____