REGIONAL ORTHOPEDIC Professional Association
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FAMILY DEMOGRAPHICS

PATIENT NAME: _____

HAVE YOU OR/AND BLOOD RELATIVE HAD ANY OF THE FOLLOWING:

		RELATIONSHIP			RELATIONSHIP
ANEMIA	YES NO	_____	SEVERE ALLERGIES	YES NO	_____
BLEEDING TENDENCY	YES NO	_____	MENTAL ILLNESS	YES NO	_____
REPEATED INFECTIONS	YES NO	_____	SEIZURES	YES NO	_____
HEART ATTACK	YES NO	_____	MIGRAINES	YES NO	_____
CHRONIC LUNG DISEASE	YES NO	_____	DIABETES	YES NO	_____
TUBERCULOSIS	YES NO	_____	GOUT	YES NO	_____
HIGH BLOOD PRESSURE	YES NO	_____	OBESITY	YES NO	_____
ASTHMA	YES NO	_____	ULCERS	YES NO	_____
CANCER/LEUKEMIA	YES NO	_____	ALCOHOL PROBLEM	YES NO	_____
FAMILY VIOLENCE/ABUSE	YES NO	_____	DRUG PROBLEM	YES NO	_____

PLEASE CIRCLE APPROPRIATE RESPONSE:

MOTHER: ALIVE / DECEASED

IF ALIVE, WHAT IS HER CURRENT HEALTH STATUS? GOOD FAIR POOR

IF DECEASED, AT WHAT AGE DID SHE PASS? _____

CAUSE OF DEATH? _____

FATHER: ALIVE / DECEASED

IF ALIVE, WHAT IS HIS CURRENT HEALTH STATUS? GOOD FAIR POOR

IF DECEASED, AT WHAT AGE DID HE PASS? _____

CAUSE OF DEATH? _____