RAINIER
ORTHOPEDIC INSTITUTE
A Division of Proliance Surgeons, Inc., P.S.

MEDICAL HISTORY

Please take the time to fill in all the blank spaces.
Use black or blue ink only.

FAMILY MEDICAL HISTORY: **Your name**_____

Please put the Correlating number beside each medical condition that applies:

1= Mother 2= Father 3=Maternal Grandmother 4=Maternal Grandfather

5=Sister 6=Brother 7=Paternal Grandmother 8=Paternal Grandfather

9=Other Family Member Example: X--- PMS 1,5 *(for mother & sister)*

__Alcoholism_____

__Anesthetic complications_____

__Anemia_____

__Anxiety_____

__Arthritis_____

__Asthma_____

__Birth Defect_____

__Bleeding Disease_____

__Breast Cancer_____

__Colon Cancer_____

__Depression_____

__Diabetes_____

__Heart Disease_____

__High Cholesterol_____

__Hypertension_____

__Kidney/Renal Disease_____

__Lung/Respiratory Disease_____

__Migraines_____

__Osteoporosis_____

__Other Cancer_____

__Angina_____

__Cervical Cancer_____

__Coronary Heart Disease_____

__Endometriosis_____

__Growth Development Disorder_____

__Headaches_____

__Lung Cancer_____

__Melanoma_____

__Other Med Problems_____

__Ovarian Cancer_____

__PMS_____

__Psychiatric Care_____

__Uterine Cancer_____

__ Weight Disorder_____

__Seizures_____

__Severe Allergies_____

__Stroke/CVA_____

__Thyroid Disorder