Texas Children's Hospital **HISTORY FORM D**

Name: _____
Current Address: _____

MOTHER'S HISTORY: Birth date: _____ Birthplace: _____
Do you use tobacco? _____ alcohol? _____ drugs of any kind? _____
Number of sisters? _____ Number of brothers? _____
If any are not living, give age at death and cause: _____
_____
Have you ever been x-rayed? _____Number of times: _____ Date of last x-ray? _____
Give reasons for x-rays or fluoroscopy? _____

PAST DISEASES	AGE	PAST DISEASES	AGE	PAST DISEASES	AGE
Measles (5 day)		Glandular fever		Worms	
Chicken pox		Infectious mononucleosis		Asthma	
German measles (3 day)		Warts		Hives	
Mumps		Cold sores		Eczema	
Roseola		Shingles		Unknown fevers	
Pneumonia		Scarlet fever		Arthritis	
Meningitis		Scarlatina		Cancer	
Encephalitis		Whooping cough		Tumor	
Pleurisy		Tuberculosis		Jaundice	
Poliomyelitis		Intestinal "flu"		Influenza (flu)	
Pericarditis		Kidney disease		Blood transfusion	
Hepatitis		Bronchitis			
Anemia		Bronchiolitis			

List any allergies, other illnesses or operations: _____
_____

FATHER'S HISTORY: Birth date: _____ Birthplace: _____
Do you use tobacco? _____ alcohol? _____ drugs of any kind? _____
Number of sisters? _____ Number of brothers? _____
If any are not living, give age at death and cause: _____
_____
Have you ever been x-rayed? _____Number of times: _____ Date of last x-ray? _____
Give reasons for x-rays or fluoroscopy? _____

PAST DISEASES	AGE	PAST DISEASES	AGE	PAST DISEASES	AGE
Measles (5 day)		Glandular fever		Worms	
Chicken pox		Infectious mononucleosis		Asthma	
German measles (3 day)		Warts		Hives	
Mumps		Cold sores		Eczema	
Roseola		Shingles		Unknown fevers	
Pneumonia		Scarlet fever		Arthritis	
Meningitis		Scarlatina		Cancer	
Encephalitis		Whooping cough		Tumor	
Pleurisy		Tuberculosis		Jaundice	
Poliomyelitis		Intestinal "flu"		Influenza (flu)	
Pericarditis		Kidney disease		Blood transfusion	
Hepatitis		Bronchitis			
Anemia		Bronchiolitis			

List any allergies, other illnesses or operations: _____
_____

SIGNATURE OF PERSON COMPLETING FORM: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____