



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Family Health History



Name of applicant father	Name of applicant mother
--------------------------	--------------------------

Check all that apply. Have you ever been treated for:	Father	Mother
• arthritis	<input type="checkbox"/>	<input type="checkbox"/>
• tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
• asthma, emphysema, or other respiratory illness	<input type="checkbox"/>	<input type="checkbox"/>
• heart disease	<input type="checkbox"/>	<input type="checkbox"/>
• eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
• ulcers	<input type="checkbox"/>	<input type="checkbox"/>
• diabetes	<input type="checkbox"/>	<input type="checkbox"/>
• recurrent headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>
• convulsions or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
• cancer	<input type="checkbox"/>	<input type="checkbox"/>
• drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
• alcohol abuse/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
• other substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
• physical handicap, including birth defect or amputation	<input type="checkbox"/>	<input type="checkbox"/>
• blood disease	<input type="checkbox"/>	<input type="checkbox"/>
• communicable disease	<input type="checkbox"/>	<input type="checkbox"/>
• hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
• blindness, eye disease, or significant vision impairment	<input type="checkbox"/>	<input type="checkbox"/>
• kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply. Have you ever:	Father	Mother
• had surgery	<input type="checkbox"/>	<input type="checkbox"/>
• been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>
• received psychological or psychiatric counseling or inpatient treatment	<input type="checkbox"/>	<input type="checkbox"/>
• received family or marital counseling	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply. Has a child in your household:	Father	Mother
• received psychological or psychiatric counseling or substance abuse treatment? If yes, list child's name. _____	<input type="checkbox"/>	<input type="checkbox"/>
• received treatment for any major health condition? If yes, list child's name. _____	<input type="checkbox"/>	<input type="checkbox"/>

Applicant father

For any box checked on page 1, complete the information below.

Condition	Dates	Treatment and results

List all prescribed and over-the-counter medications you are currently taking and for what condition.

Current condition	Medication	Dosage	Frequency

Applicant mother

For any box checked on page 1, complete the information below.

Condition	Dates	Treatment and results

