PATIENT NAME: ____ DATE OF BIRTH:_________________________________

FAMILY MEDICAL HISTORY

Adopted:_____________ NO Known Family History	CIRCLE IF APPLICABLE				NO FAMILY HISTORY OF
Alcoholism	Mother	Father	Sister (s)	Brother (s)	
Alzheimer's Disease	Mother	Father	Sister (s)	Brother (s)	
Anemia	Mother	Father	Sister (s)	Brother (s)	
Arthritis	Mother	Father	Sister (s)	Brother (s)	
Asthma	Mother	Father	Sister (s)	Brother (s)	
Blood Disorder	Mother	Father	Sister (s)	Brother (s)	
Cancer: **Type=**	Mother	Father	Sister (s)	Brother (s)	
Heart Disease	Mother	Father	Sister (s)	Brother (s)	
CHF	Mother	Father	Sister (s)	Brother (s)	
COPD	Mother	Father	Sister (s)	Brother (s)	
Depression	Mother	Father	Sister (s)	Brother (s)	
Diabetes (1 or 2)	Mother	Father	Sister (s)	Brother (s)	
Gout	Mother	Father	Sister (s)	Brother (s)	
Hearing loss	Mother	Father	Sister (s)	Brother (s)	
High Cholesterol	Mother	Father	Sister (s)	Brother (s)	
Hypertension	Mother	Father	Sister (s)	Brother (s)	
Kidney Disease	Mother	Father	Sister (s)	Brother (s)	
Liver Disease	Mother	Father	Sister (s)	Brother (s)	
Mental Disorder	Mother	Father	Sister (s)	Brother (s)	
Migraines	Mother	Father	Sister (s)	Brother (s)	
Obesity	Mother	Father	Sister (s)	Brother (s)	
Osteoporosis	Mother	Father	Sister (s)	Brother (s)	
Parkinsons Disease	Mother	Father	Sister (s)	Brother (s)	
Peripheral Vascular	Mother	Father	Sister (s)	Brother (s)	
Seizure Disorder	Mother	Father	Sister (s)	Brother (s)	
Stroke	Mother	Father	Sister (s)	Brother (s)	
Thyroid Disease	Mother	Father	Sister (s)	Brother (s)	
OTHER:	Mother	Father	Sister (s)	Brother (s)	