FAMILY MEDICAL HISTORY FORM

PATIENT ID NO. _____

Please indicate with a (✔) in boxes below family members who have had any of the following:

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's Mom's	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism														
Allergies: Bee Sting or Poison Oak														
Allergies: Food														
Allergies: Other														
Anesthesia problem														
Anxiety / Panic Attacks														
Arthritis														
Asthma														
Attention Deficit disorders (ADD or ADHD)														
Birth Defects														
Blood problem / Clotting disorder														
Bone / Joint problems														
Breast Disease / Lumps (Benign)														
Cancer, Breast														
Cancer, Colon														
Cancer, Melanoma														
Cancer, Ovary														
Cancer, Prostrate														
Chicken Pox														
Colitis or Colon problems														
Depression (of a Serious Nature)														
Diabetes, Type 1 (Childhood Onset)														
Diabetes, Type 2 (Adult Onset)														
Digestive Tract problem														
Ear / Nose / Throat Problems														
Eating Disorders														
Eczema														
Epilepsy (convultions or seizures)														
Fertility (conception) problems														
Gallbladder or Gallstones														
Gynecology problems														
Hay Fever														
Headaches: Migranes or Frequent														
Hearing problems: Loss														
Heart Attack / Over age 60														
Heart Attack / Under age 60														
Heart Murmur														
Heart problem														
Hepatitis A, B or C														
High Blood Pressure (Hypertension)														
High Cholesterol (Hyperlipidemia)														