FAMILY MEDICAL HISTORY FORM

Mail to:

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)														

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Mail to:

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
Immune disorder: HIV or AIDS (Human Immunodefiiciency Virus)														
Immune disorder: Other than HIV or AIDS														
Kidney / Urinary Tract problems														
Lukemia														
Lung disease														
Menstral problems														
Mental Illness														
Mental Retardation														
Miscarriage														
Neck / Back problems														
Osteoporosis														
Psychiatriac Treatment														
Rheumatic Fever														
Scarlet Fever														
Sexually Transmitted Disease														
Skin problems														
Smoking / Tobacco use														
Spinal Cord Disruption														
Stomach disease														
Stroke / Over age 60														
Stroke / Under age 60														
Substance Abuse / Recreational Drug Use														
Thyroid disorders														
Tuberculosis														
Tumors or Cyst														
Ulcers: Gastric or Duodenal														
Virus or Infections														
Vision Problem other than Eyeglasses														
Vision: Eyeglasses														
Weight: Obesity														
Weight: Overweight														
Weight: Underweight														
OTHER: Specity type_____														
OTHER: Specity type_____														

NEXT OF KIN:

In case of a medical emergency or death of _____ do you wish to be or to have someone notified? ___ YES ___ NO please indicate answer with a check (✔) on the line.

If yes, whom:

Name / Relationship _____ Telephone _____

Address/ City / State _____ e-mail _____

FAMILY MEDICAL HISTORY FORM

Mail to:

PATIENT ID NO._____

Please indicate with a (✔) in boxes below the current health status of your immediate family members

				HEALTH STATUS			
			AGE	Check (✔) one box			COMMENTS: Signifigant Medical Problems, Genetic Diseases, Any Major Surgeries, Occupation, Cause of Death
	ALIVE	DEAD	(now or at death)	Excellent	Average	Poor	
Mother							Mother Comments:
Father							Father Comments:
Sister(s) #_____							Sister(s) Comments:
Brother(s) #_____							Brother(s) Comments:
Daughter(s) #_____							Daughter(s) Comments:
Son(s) #_____							Son(s) Comments:

List any previous hospitalizations / surgeries

YEAR	DIAGNOSIS	TREATMENT / OPERATION	ANY COMPLICATIONS

ANY ADDITIONAL COMMENTS: