Patient Name:

Family Medical History

Please mark an x next to all that apply indicating the relationship to which each applies

	Father	Mother	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Alcoholism								
Anemia								
Anxiety								
Arthritis								
Asthma								
B-12 Deficiency								
Blood Disorder								
COPD								
Cancer								
Depression								
Diabetes Type 1								
Diabetes Type 2								
Drug Abuse								
Epilepsy								
Glaucoma								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Low Blood Pressure								
Low Blood Sugar								
Stroke								
Thyroid Disease								

Immediate Family

Mother Living Deceased Age:

Father Living Deceased Age:

Number of sisters, Living: _____ Deceased: _____ Age of Death: _____ Cause:

Number of brothers, Living: _____ Deceased: _____ Age of Death: _____ Cause:

Do any diseases run in your family? Yes No

If yes, please describe: