FAMILY HISTORY

Patient Name: _____ Patient DOB: _____ Today's Date: _____

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

Family Members	Status – (Circle Status)	Year of Birth	Age	Diabetes	High Blood Pressure	Heart Problems	Stroke	Cancer	Asthma	High Cholesterol	Obesity	Seizures	Mental Problems	Thyroid problems	Other
Mother	alive deceased unknown														
Father	alive deceased unknown														
Sister(s)	alive deceased unknown														
Brother(s)	alive deceased unknown														
Paternal Grandmother	alive deceased unknown														
Paternal Grandfather	alive deceased unknown														
Maternal Grandmother	alive deceased unknown														
Maternal Grandfather	alive deceased unknown														
Other – Relationship to Patient	alive deceased unknown														
Siblings	Patient has how many brothers?	Patient has how many Sisters?	Are Siblings healthy?												
				Notes:											