Reviewed: _____

Date:_____

Family Medical History

Patient's Name: _____ DOB: _____

Please check all items that each family member may have had or currently has.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling	Sibling	Sibling	Sibling	Half Sib	Half Sib	Half Sib	Half Sib
Childhood hearing loss														
Food allergies														
Environmental allergies														
Asthma														
Early heart attacks (before 55 in men, 65 in women)														
High cholesterol														
Hypertension (high blood pressure)														
Sudden unexpected death not due to accident														
Bleeding disorder														
Clotting disorder														
Cancer Type: _____														
Liver disease Type: _____														
Kidney disease including kidney stones Type: _____														
Diabetes: Type 1 _____ Type 2 _____														
Epilepsy / convulsions / seizures														
Developmental disability														
Genetic disorders														
Autoimmune disorders														
Thyroid disease: Hypo (low)_____ Hyper (high)_____ Other_____														
Infectious diseases (HIV,AIDS,HepC, etc.) Type: _____														
ADHD														
Bed-wetting after age 5														
Depression														
Anxiety														
Other mental illness														
Alcohol abuse														
Drug abuse Type: _____														
Other inherited conditions Type: _____														