FAMILY MEDICAL HISTORY

PATIENT INFORMATION

Last Name: _____ Middle: _____

First Name: _____ Gender : _____

Phone # : _____ DOB: _____

Ethnicity: _____ Twin: Yes ☐ No ☐

Allergies: _____

_____

	Health Conditions:	Age When Diagnosed:
Examples: Heart disease, cancer, dementia, diabetes, arthritis, asthma, stroke, poor cholesterol, other.		

NUMBER OF FAMILY MEMBERS

Related by blood, living or deceased

Grandmother : _____ Grandfather : _____

Mother: _____ Father: _____

Aunts: _____ Uncles : _____

Sisters : _____ Brothers: _____

Daughters : _____ Sons : _____

Half Sisters : _____ Half Brothers : _____

Immediate Blood Family: Parents, Siblings, and Children

Name	Relationship	DOB	Health Condition	Age at Diagnosis	Living? (Y/N)	Age at Death

Mother's Blood Family: Her Parents and Siblings

Name	Relationship	DOB	Health Condition	Age at Diagnosis	Living? (Y/N)	Age at Death

Father's Blood Family: His Parents and Siblings

Name	Relationship	DOB	Health Condition	Age at Diagnosis	Living? (Y/N)	Age at Death