Family Medical History

Patient Name: _____

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Autism												
Asthma												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Disorder												
Cancer, Breast												
Cancer: (Specify)												
Cancer: (Specify)												
Depression												
Type I Diabetes												
Type II Diabetes												
Eczema (Atopic Dermatitis)												
Food Allergy												
Genetic Disorder												
Hay Fever (Allergic Rhinitis)												
Hearing Disorder												
Heart Attack/Coronary Artery Disease												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Inflammatory Bowel Disease (Crohn's/UC)												
Kidney Disease												
Intellectual or Learning Disability												
Migraine Headaches												
Psychiatric Disorder/ Mental Health Disorder												
Scoliosis												
Stroke												
Substance Abuse												
Thyroid Disorder												
Tobacco Use												
Tuberculosis												
Death before 56												
Other												

Informant: _____ Date: _____

Reviewed by: _____