

FAMILY MEDICAL HISTORY FORM

Mail to:

PATIENT ID NO. _____

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

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's Mom's	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Immune disorder: HIV or AIDS (Human Immunodeficiency Virus)														
Immune disorder: Other than HIV or AIDS														
Kidney / Urinary Tract problems														
Lukemia														
Lung disease														
Menstral problems														
Mental Illness														
Mental Retardation														
Miscarriage														
Neck / Back problems														
Osteoporosis														
Psychiatric Treatment														
Rheumatic Fever														
Scarlet Fever														
Sexually Transmitted Disease														
Skin problems														
Smoking / Tobacco use														
Spinal Cord Disruption														
Stomach disease														
Stroke / Over age 60														
Stroke / Under age 60														
Substance Abuse / Recreational Drug Use														
Thyroid disorders														
Tuberculosis														
Tumors or Cyst														
Ulcers: Gastric or Duodenal														
Virus or Infections														
Vision Problem other than Eyeglasses														
Vision: Eyeglasses														
Weight: Obesity														
Weight: Overweight														
Weight: Underweight														
OTHER: Specity type _____														
OTHER: Specity type _____														

NEXT OF KIN:

In case of a medical emergency or death of _____ do you wish to be or to have someone notified? ___ YES ___ NO please indicate answer with a check (✓) on the line.

If yes, whom:

Name / Relationship _____

Telephone _____

Address/ City / State _____

e-mail _____

FAMILY MEDICAL HISTORY FORM

Mail to:

PATIENT ID NO. _____

Please indicate with a (✓) in boxes below the current health status of your immediate family members

	HEALTH STATUS			COMMENTS:		
	ALIVE	DEAD	AGE	Check (✓) one box		
			(now or at death)	Excellent	Average	Poor
Mother						Mother Comments:
Father						Father Comments:
Sister(s) #						Sister(s) Comments:
Brother(s) #						Brother(s) Comments:
Daughter(s) #						Daughter(s) Comments:
Son(s) #						Son(s) Comments:

List any previous hospitalizations / surgeries

YEAR	DIAGNOSIS	TREATMENT / OPERATION	ANY COMPLICATIONS

ANY ADDITIONAL COMMENTS: