Patient Name: _____

Date of Birth: _____ Adopted _____ Yes _____ No (please circle)

Family History: Please indicate which relative has had the following diseases (parents and siblings are highest priority).

If history of one or more family member is unknown, place a check in the box next to the corresponding person(s). *

Relationship: _____ Disease:	Mother ☐	Father ☐	Sister ☐	Brother ☐	Grandfather (Maternal) ☐	Grandmother (Maternal) ☐	Grandfather (Paternal) ☐	Grandmother (Paternal) ☐	Other (relationship):
Addiction (i.e. substance abuse)									
Alcohol abuse									
Alzheimer's disease									
Bleeding disorder									
CA-Breast cancer									
CA-Colon cancer									
CA-Lung cancer									
CA-Ovarian cancer									
Cancer-Unknown origin									
COPD									
Depression									
Diabetes mellitus type 1									
Diabetes mellitus type 2									
Heart attack									
Heart disease									
High blood pressure									
Hypercholesterolemia									
Kidney disease									
Mental illness									
Migraines									
Muscular Sclerosis									
Osteoporosis									
Parkinsons									
Stroke									
Thyroid									

OTHER SIGNIFICANT FAMILY HISTORY (include relationship and disease): _____

_____