Account Number: _____

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

FAMILY MEDICAL HISTORY

Disease			If yes, please indicate which relative
Allergies	NO ☐	YES ☐	_____
Asthma	NO ☐	YES ☐	_____
Autoimmune disorder	NO ☐	YES ☐	Type: _____
Blood disorder	NO ☐	YES ☐	_____
Brain disorder	NO ☐	YES ☐	_____
Cancer	NO ☐	YES ☐	Type: _____
Cystic fibrosis	NO ☐	YES ☐	_____
Deafness	NO ☐	YES ☐	Age of onset: _____
Diabetes	NO ☐	YES ☐	Type 1 ☐ Type 2 ☐
Gastrointestinal disorder	NO ☐	YES ☐	Type: _____
Genetic disorder	NO ☐	YES ☐	Type: _____
Headaches or Migraines	NO ☐	YES ☐	_____
Heart disease	NO ☐	YES ☐	Death before age 50 YES ☐ NO ☐
High blood pressure	NO ☐	YES ☐	_____
High cholesterol	NO ☐	YES ☐	_____
Immunologic disorder	NO ☐	YES ☐	Type: _____
Intellectual or learning disability	NO ☐	YES ☐	_____
Kidney disease	NO ☐	YES ☐	Type: _____
Mental illness/ Substance abuse	NO ☐	YES ☐	Specify: _____
Seizures	NO ☐	YES ☐	_____
Sickle cell disease	NO ☐	YES ☐	_____
Tuberculosis	NO ☐	YES ☐	_____

Completed by: _____ Relationship **to patient:** _____

Signature: _____ **Date**: ____/____/____