Name:_____ Date:_____

Family Medical History Form

Indicate your family members who have had the following. State the person's name and age when they had the problem if you know it.

Medical Condition	Names of Family Member(s)	Age
Alcoholism		
Allergies		
Aneurysm		
Alzheimer's Disease		
Asthma		
Arthritis		
Autoimmune Disease		
Birth Defects		
Breast Cancer		
Cancer		
Cardiovascular Disease		
Colon Cancer		
Colon Polyps		
COPD (LungDisease)		
Deep Vein Thrombosis		
Depression		
Diabetes		
Eating Disorder		
Heart Disease		
High Cholesterol		
Hypertension		
Kidney Disease		
Liver Disease		
Mental Illness		
Obesity		
Osteoporosis		
Prostate Cancer		
Pulmonary Embolism		
Respiratory Disease		
Stroke		

Thyroid Disease		
Other(List)		
Other(List)		
Other(List)		
Alive (Yes, No, or N/A=Not Applicable)		

Checklist

- [ ] Have a conversation with your blood relatives about any potential chronic or severe diseases diagnosed in the family.
- [ ] Ask questions about the diagnoses, including the age, type of illness, or any information that will be helpful to you and your children.
- [ ] Talk to your doctor about steps that can be preventative or ways to lower the chances of getting the disease or illness.

Note to Self

Please list any additional notes you want to record about you or your family.