Today's Date:________________

Name of Patient____ DOB _______________

FAMILY MEDICAL HISTORY- ESTABLISHED PATIENT

Adoption? ❑ yes ❑ no Age at adoption?_________ What Country adopted from?___________

Has anyone in your family had: (parents, grandparents, aunts, and uncles)

Illness		Relationship	Illness		Relationship
High Blood Pressure	❑ yes ❑ no		Cleft Lip	❑ yes ❑ no	
Heart Attack at age <60	❑ yes ❑ no		Depression	❑ yes ❑ no	
Diabetes	❑ yes ❑ no		Drinking Problems	❑ yes ❑ no	
Stroke at age	❑ yes ❑ no		Drug Problems	❑ yes ❑ no	
Cancer	❑ yes ❑ no		Hearing Problems (not due to old age)	❑ yes ❑ no	
Thyroid Problems	❑ yes ❑ no		Skipped Heartbeats/Heart Rhythm Problems	❑ yes ❑ no	
Allergic Disorders (Hay fever, Eczema)	❑ yes ❑ no		High Cholesterol	❑ yes ❑ no	
Seizures	❑ yes ❑ no		HIV/AIDS Complex	❑ yes ❑ no	
Sickle Cell Anemia	❑ yes ❑ no		Hypertrophic/ Dilated Cardiomyopathy	❑ yes ❑ no	
Asthma	❑ yes ❑ no		Immune Disorders	❑ yes ❑ no	
Tuberculosis	❑ yes ❑ no		Kidney Problems	❑ yes ❑ no	
Mental Illness	❑ yes ❑ no		Learning Problems	❑ yes ❑ no	
Migraine Headaches	❑ yes ❑ no		Liver Problems	❑ yes ❑ no	
Anemia	❑ yes ❑ no		Long - QT Syndrome	❑ yes ❑ no	
Anxiety	❑ yes ❑ no		Lung Problems	❑ yes ❑ no	
Arthritis	❑ yes ❑ no		Malignant Hyperthermia	❑ yes ❑ no	
Bipolar Disorder	❑ yes ❑ no		Marfan Syndrome	❑ yes ❑ no	
Heart Malformation	❑ yes ❑ no		Mental Retardation	❑ yes ❑ no	
Bowel/ Intestinal Problems	❑ yes ❑ no		Suicide Attempt	❑ yes ❑ no	