FAMILY HEALTH HISTORY

PATIENT NAME _____ DATE OF BIRTH _____/_____/_____

BIOLOGICAL PARENT #1 _____

BIOLOGICAL PARENT #2 _____

SIBLINGS WITH SAME BIOLOGICAL PARENTS _____

IF PATIENT IS ADOPTED WITH UNKNOWN FAMILY HISTORY PLEASE CHECK THIS BOX ☐

	MOM	DAD	MOMS MOM	MOMS DAD	DADS MOM	DADS DAD	SIBLINGS	TYPE (IF KNOWN)
Asthma	☐	☐	☐	☐	☐	☐	☐	
Allergies*	☐	☐	☐	☐	☐	☐	☐	
Autoimmune Disorder*	☐	☐	☐	☐	☐	☐	☐	
Bleeding Disorder*	☐	☐	☐	☐	☐	☐	☐	
Cancer*	☐	☐	☐	☐	☐	☐	☐	
Congenital Deafness	☐	☐	☐	☐	☐	☐	☐	
Diabetes*	☐	☐	☐	☐	☐	☐	☐	
Genetic Disorder*	☐	☐	☐	☐	☐	☐	☐	
Heart Disease*	☐	☐	☐	☐	☐	☐	☐	
Heart Attack Before 50	☐	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	
Obesity	☐	☐	☐	☐	☐	☐	☐	
Psychiatric Disorder*	☐	☐	☐	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐	
Substance Abuse*	☐	☐	☐	☐	☐	☐	☐	
Thyroid Disorder*	☐	☐	☐	☐	☐	☐	☐	

* Please provide type, if known