

FAMILY HISTORY

Last Name: _____ **First Name:** _____ **MI:** _____ **Date of Birth:** _____

Please mark below if there is a personal or family history of any of the following diseases. If yes to any, indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, siblings, grandparents, aunts and uncles, and cousins.

FOR EXAMPLE	YOU	age	SIBLINGS/ CHILDREN	age	MOTHER'S SIDE	age	FATHER'S SIDE	age
Colorectal Cancer	None	—	Brother	36	Aunt Cousin	44 58	Grandfather	65

Disease	You	age	Sibling's/ Children	age	Mother's Side	age	Father's Side	age
Heart Disease								
High Blood Pressure								
Diabetes								
Breast Cancer								
Ovarian Cancer								
Pancreatic cancer								
Uterine (Endo) Cancer								
Colorectal Cancer								
Melanoma								
Epilepsy								
Kidney Disease								
Digestive Problems								
Lung Disease								
Thyroid Disease								
Osteoporosis								
Hepatitis								
Colitis								
Gallbladder Disease								
Emphysema								
Fibroids								
Endometriosis								
Other (explain in the space provided below)								
