Family Health History Questionnaire

Patient Name_____ #_____ Date:_____

Please list **IMMEDIATE** family members who have/has had any potentially genetic health issues to the best of your knowledge. Examples of these health issues are listed below:

Arthritis	Asthma	Back Pain	Cancer	Depression
Diabetes	Epilepsy	Genetic Spinal Condition		Hypertension (high/low)
Heart Disease/Stroke		Mental Illness		Multiple Sclerosis
Neurological Problems		Parkinson's Disease		Polio

Father _____

Mother _____

Sibling(s) _____

Paternal Grandfather _____

Paternal Grandmother _____

Maternal Grandfather _____

Maternal Grandmother _____

Other family member(s): _____

_____