FAMILY HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Family Record: Check condition(s) and relationship of any blood relative who has or had any of the conditions listed below. Use comment line for "yes" answers.

F=Father, M=Mother, B=Brother, S=Sister

	F	M	B	S	Comments
Alcoholism	___	___	___	___	_____
Anemia	___	___	___	___	_____
Asthma	___	___	___	___	_____
Bleeding Tendency	___	___	___	___	_____
Cancer	___	___	___	___	_____
Heart Disease	___	___	___	___	_____
Diabetes	___	___	___	___	_____
Emphysema	___	___	___	___	_____
Epilepsy	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
Kidney Disease	___	___	___	___	_____
Leukemia	___	___	___	___	_____
Liver Disease	___	___	___	___	_____
Mental Illness	___	___	___	___	_____
Multiple Sclerosis	___	___	___	___	_____
Nervous Breakdown	___	___	___	___	_____
Overweight	___	___	___	___	_____
Sickle Cell Anemia	___	___	___	___	_____
Stroke	___	___	___	___	_____
Suicidal Tendencies	___	___	___	___	_____

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	Living Age	Health	Deceased Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____

To the best of my knowledge I attest that the information stated on this document is true and accurate.

Signed _____ Date _____