

FAMILY MEDICAL HISTORY

PLEASE REPORT ANY CHANGES SINCE YOU LAST COMPLETE PHYSICAL

Name:		DOB:		Age:	Date:
IMMEDIATE FAMILY		Living?		Age	Significant health issues (or cause of death)
		Yes	No		
<input type="checkbox"/> Mother		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Father		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		

DISTANT RELATIVES PLEASE REPORT ANY NEW DISEASES OR SIGNIFICANT HEALTH ISSUES IN GRANDPARENTS, AUNTS, UNCLAS, AND COUSINS SINCE YOUR LAST COMPLETE PHYSICAL (INDICATE SPECIFIC RELATIVE, e.g. MATERNAL COUSIN)

Cancer

Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):

Rheumatoid arthritis, gout, or other crippling arthritis (*indicate diagnosis for each relative affected*)

Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

Serious psychiatric illness (*nervous breakdown, mental hospitalization, suicide attempt*)

Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

Coronary artery disease (*heart attack, angioplasty, bypass surgery*). Indicate approximate age of onset for each relative.

Aneurysm:	Stroke:
Kidney disease:	Peptic ulcer disease:
Kidney stones:	Tuberculosis:
Diabetes:	High blood pressure:

Other significant diseases (*include those that "run in the family"*):

Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

Pre-visit instructions for laboratory tests:

- ▶ Fast after 12:00 midnight the night before the exam. ▶ Patients may have water, black coffee, plain tea the morning of the exam. ▶ Medications are to be taken as usual except for patients using insulin. ▶ Patients taking insulin should bring a light breakfast and their insulin. Inject insulin & eat breakfast after blood is drawn.

Thank you for helping us with this information. We look forward to seeing you.