FAMILY HISTORY

Name:_____ Date of birth:_____

Do you have any first degree relatives (**MOTHER, FATHER, SIBLINGS or CHILDREN**) who have or had the following? Please check √ the ones that apply.

	Mother	**Father**	**Brother**	**Sister**	**Son**	**Daughter**
Alcoholism						
Anemic						
Anesthetic complications						
Anxiety						
Arthritis						
Asthma						
Birth Defect						
Bleeding Disorder						
Breast Cancer						
Cervical Cancer						
Colon Cancer						
Depression						
Diabetes						
Endometriosis						
Heart Disease						
Headache						
High Blood Pressure						
High Cholesterol						
Kidney/renal disease						
Lung Cancer						
Lung Resp/disease						
Melanoma						
Migraines						
Osteoporosis						
Ovarian Cancer						
Psychiatric Care						
Seizures						
Severe allergies						
Strokes/CVA						
Thyroid Disease						
Uterine Cancer						
Weight Disorder						
Other Cancers						
Other Problems						