Family Medical History Intake Sheet

Please complete this form to the best of your knowledge. This information is confidential and will help us provide the best possible care.

Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY): Today's Date:

Immediate Family Status

Relative	Status (Alive / Deceased)	Current Age or Age at Death	Cause of Death / Major Health Issues
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Family Medical History

Please indicate if any of your biological relatives (parents, grandparents, siblings, aunts, uncles) have had any of the following conditions. Write "Yes", "No", or "Unknown", and list the specific relative(s) and their age of diagnosis if known.

Medical Condition	Diagnosis (Yes / No / Unknown)	Affected Relative(s) (e.g., Mother, Brother)	Approximate Age at Diagnosis
Heart Disease / Heart Attack			
High Blood Pressure (Hypertension)			
Stroke			
High Cholesterol			
Diabetes (Specify Type 1 or 2)			
Cancer (Specify type: breast, colon, lung, etc.)			
Alzheimer's Disease / Dementia			
Mental Health Issues (Depression, Anxiety, Bipolar)			
Asthma / Lung Disease			
Kidney Disease			
Alcohol / Substance Abuse			
Other Hereditary Conditions			

Additional Comments

Please write any other important family medical history details below: