

Highlands Family Medicine

Patient Name _____

Date of Birth _____

Today's Date _____

PATIENT FAMILY HISTORY QUESTIONNAIRE

In order to help your provider with your health assessment today, please complete the following family history form. We would like you to include information for blood relatives only.

Under "Medical History" it is most useful to know current and past history of diseases that can be inherited by other family members. This includes cancer (what type, if known), heart or artery disease (include heart attack, bypass surgery, angioplasty/stent, stroke), diabetes, arthritis and other diseases of which you are aware.

	Alive or Deceased?	Age now or at Time of death?	Medical History
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncles			

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Paternal Aunts			
Maternal Uncles			
Maternal Aunts			
Siblings			
Children			
Do you...	Yes or No	If yes, in what form, and how much in an average day or week?	
Use tobacco products?			
Drink alcohol products?			
Drink/use caffeine products?			
Exercise regularly?			
Work or volunteer outside the home?			