Name: _____ Today's date: _____

FAMILY HISTORY

Please circle all illnesses/conditions which you know have occurred in your blood relatives. If possible list the affected family member. Circle None if you are not aware of any relative having an illness/condition

None

Illness / Condition

Complications with anesthesia
Anxiety
Birth defects
Blood clots
Depression
Diabetes
Growth/development
Heart disease
Hypertension (high blood pressure)
High cholesterol
Psychiatric care
Osteoporosis
Seizures
Seasonal allergies
Stroke
Bowel disease
Kidney disease
Respiratory disease
Liver disease
Ulcers
Congestive heart failure <55
Thyroid disease
Weight disorder
Headaches
Cancer type _____

Other: