



South Metro Office: 9785 Maroon Circle St, Englewood, CO 80112 (303) 779-1172
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FAMILY MEDICAL HISTORY

DATE ____/____/____

PATIENT AND SIBLINGS NAMES _____

MOTHER'S NAME _____ DATE OF BIRTH ____/____/____

OCCUPATION _____ MEDICAL PROBLEMS _____

FATHER'S NAME _____ DATE OF BIRTH ____/____/____

OCCUPATION _____ MEDICAL PROBLEMS _____

SMOKER? YES/NO _____

* LIST ALL OTHER RELATIVES OF CHILD THAT HAS/HAD SIGNIFICANT MEDICAL PROBLEMS, THEIR AGE AT DEATH IF APPLICABLE: EG (AUNT, ASTHMA, DIED AGE 47)

RELATIVE	MEDICAL PROBLEM/CAUSE OF DEATH
_____	_____
_____	_____
_____	_____
_____	_____

IS THERE A FAMILY HISTORY OF: ASTHMA _____

ALLERGIES _____

HIGH CHOLESTEROL _____

HEART ATTACK OR STROKE BEFORE AGE 60 _____

*SIGNIFICANT FAMILY HISTORY PROBLEMS INCLUDE, BUT ARE NOT LIMITED TO: CANCER (SPECIFY TYPE), DIABETES, THYROID PROBLEMS, HEART ATTACK, STROKE, SEIZURE DISORDER, PSYCHIATRIC ILLNESS, ALCOHOLISM, HEARING LOSS, KIDNEY PROBLEMS, CONGENITAL PROBLEMS, COLITIS AND ASTHMA.