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FAMILY HISTORY:

Father's Name: ____
Mother's Name: ____
Child's/Children's' Names: ____

Is there any history of the following conditions in the family? Please specify the family member with the condition.

Asthma: Yes No Which family member? __________________________
COPD: Yes No Which family member? __________________________
High Blood Pressure: Yes No Which family member? __________________________
High Cholesterol: Yes No Which family member? __________________________
Coronary heart disease: Yes No Which family member? __________________________
Heart Attack: Yes No Which family member? __________________________
Diabetes Type 1: Yes No Which family member? __________________________
Diabetes Type 2: Yes No Which family member? __________________________
Thyroid Disease: Yes No Which family member? __________________________
Alcoholism: Yes No Which family member? __________________________
Mental illness: Yes No Which family member? __________________________
If Yes, please specify type (Anxiety, Depression, Schizophrenia, Bipolar, etc..) and which family member:
____

Blood Disorders: Yes No Which family member? __________________________
Colorectal cancer: Yes No Which family member? __________________________
Reproductive Cancer: Yes No Which family member? __________________________
If Yes, please specify type (Breast, Uterine, Ovarian, Prostate, etc.) and which family member:
____

Other Cancers: Yes No Which family member? __________________________
Stroke: Yes No Which family member? __________________________
Other:__________________________

If child is adopted please fill the information below:

Adoptive Father's Name: ____
Adoptive Mother's Name: ____
Child's/Children's' Names: ____