PERSON FAMILY MEDICAL AND DENTAL CENTER

PERSONAL and FAMILY HISTORY ABOVE the Age of 10

Name: _____ **Date of Birth:** _____

List family members kin by blood that are deceased, cause of death (if known) and approximate age at time of death.

_____

_____

_____

How many brothers do you have? _____ How many sisters do you have? _____

Patient Medical History	YES	DENIES
ADD/ADHD		
Alcoholism/Drugs		
Anemia		
Asthma		
Cancer (Please write type)		
Diabetes		
Epilepsy/Convulsions/Seizures		
Heart Problems (Please write type)		
High Blood Pressure		
High Cholesterol		
Kidney Problems		
Mental Illness (Please write type)		
Migraines		
Pneumonia		
Sickle Cell/Thal./Anemia		
Sleep Apnea		
Stroke		
Thyroid Disease (Hyper or Hypo)		
Other		

PATIENT MEDICAL HISTORY

List any **OTHER medical conditions** not listed above (diagnosis, if known) you have or have had, and how long you have had these problems (approximately). Write "none" if there are NO OTHERS.

_____

_____

_____

_____

List the **SURGERIES** (diagnosis, if known) you have had, when the surgeries were performed (approximately), and at what hospital. Write "none" if there are none.

_____

_____

_____

_____

List **HOSPITAL ADMISSIONS**. Include when (approximately), what hospital, and the reason you were admitted. Include important emergency room visits and severe accidents. Write "none" if there are none.

_____

_____

_____

_____

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(Place a check mark in the appropriate columns as it applies to your family. Check all that apply.)

Family Medical History	MOM	DAD	CHILDREN	BROTHER	SISTER	MOTHER'S MOM	MOTHER'S DAD	FATHER'S MOM	FATHER'S DAD
Alcoholism/Drugs									
Asthma									
Cancer (Please write type)									
Diabetes									
Epilepsy/Convulsions/Seizures									
Heart Problems (Please write type)									
Hepatitis									
High Blood Pressure									
High Cholesterol									
Kidney Problems									
Mental Illness (Please write type)									
Migraines									
Sickle Cell/Thal./Anemia									
Stroke									
Thyroid Disease (Hyper or Hypo)									
Other									