

Optional Family Health History Questionnaire

Instructions: Fill out one of these questionnaires for yourself and make copies for others to fill out. You can also fill out a questionnaire for people who are deceased or cannot do it themselves. *Not all health conditions are listed.* Many other conditions, including many mental health conditions and single gene disorders also run in families.

Name: _____ Today's Date: _____

Place of Birth: _____ Date of Birth: _____

If Deceased
Cause of Death: _____ Date of Death: _____

Ethnicity: _____

<u>Health history</u>	<u>Yes</u>	<u>No</u>	<u>Not sure</u>	<u>Age of onset</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease or heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes/sugar disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Types: _____				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Types: _____				
Vision loss/hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Miscarriage/Stillbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
How many? _____				

Check one:

_____ Smoker _____ Ex-Smoker _____ Non-Smoker _____ Not Sure

Other Health Concerns:
