Family Member Name: _____

Family Medical Health History Form - FREE Version

Complete all the fields as best you can. The form does not have to be complete but every piece of information helps. Include at least 3 generations of family members, if possible, to provide your doctors the most complete picture of your family's medical history.

Your Personal Medical History

Your Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except			

Want to TYPE in your answers so you can SAVE them? Get a Fillable, Saveable PDF version of this form at:
www.Free-Family-Medical-History-Form.com

Family Member Name: _____

melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			
Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Your Spouse

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth	Place of Birth	Gender
Ethnic Background	Current Health Status	Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Your Parents

Your Father

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			

Family Member Name: _____

Diabetes, Type 1 (childhood onset)			
Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

_____

_____

_____

List any Hospitalizations

Hospital City Reason Date Result

_____

_____

_____

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

_____

_____

_____

Family Member Name: _____

Your Mother

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth	Place of Birth	Gender
Ethnic Background	Current Health Status	Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

_____

_____

_____

List any Hospitalizations

Hospital City Reason Date Result

_____

_____

_____

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

_____

_____

_____

Family Member Name: _____

Your Grandparents

Your Grandfather

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth	Place of Birth	Gender

Ethnic Background	Current Health Status	Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			

Family Member Name: _____

Diabetes, Type 1 (childhood onset)			
Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Your Grandmother

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Spouse's Parents

Spouse's Father

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			

Family Member Name: _____

Diabetes, Type 1 (childhood onset)			
Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Spouse's Mother

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth	Place of Birth	Gender
Ethnic Background	Current Health Status	Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Spouse's Grandparents

Spouse's Grandfather

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			

Family Member Name: _____

Diabetes, Type 1 (childhood onset)			
Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Spouse's Grandmother

Full Name (First, Middle, Last)

Maiden or Former Name(s)

Date of Birth	Place of Birth	Gender
Ethnic Background	Current Health Status	Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Brother Or Sister 1

Full Name (First, Middle, Last)

Maiden or Former Name(s) | Full/Half/Step Sibling

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems:

Family Member Name: _____

Brother Or Sister 2

Full Name (First, Middle, Last)

Maiden or Former Name(s) | Full/Half/Step Sibling

Date of Birth | Place of Birth | Gender

Ethnic Background | Current Health Status | Today's Date

Condition	Age at Onset	Treatment	Result
Alzheimer's Disease			
Allergic Rhinitis (Hay fever)			
Anemia			
Anesthesia Problem			
Arthritis			
Asthma			
Birth Defects			
Bleeding Problem			
Cancer, Breast			
Cancer, Colon			
Cancer, Lung			
Cancer, Melanoma			
Cancer, Prostate			
Cancer, Skin (except melanoma)			
Cancer, Ovarian			
Cancer (other)			
Depression			
Diabetes, Type 1 (childhood onset)			

Family Member Name: _____

Diabetes, Type 2 (adult onset)			
Epilepsy (seizures)			
Eye Conditions			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Lupus			
Mental Retardation			
Migraine Headaches			
Miscarriage			
Osteoarthritis			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			
Thyroid Disorders			
Tuberculosis			
Ulcer			
Other:			

Family Member Name: _____

Other Factors

Condition	Age at Onset	Treatment	Result
Alcoholism			
Drug Use			
Obesity			
Smoking			

List any other major diseases, surgeries, conditions, or illnesses not covered above:

List any Hospitalizations

Hospital City Reason Date Result

Has this person had any other birth defects, mental retardation, miscarriages, psychological illness, or other medical concerns not yet mentioned? Please detail the problems: