Your Family Medical History Questionnaire

Even if you're healthy now, knowing your family health history will provide important clues to your future health and the future health of your family. Do certain diseases and health conditions run in your family? If you're unsure, begin collecting your family health history today by using this easy to follow questionnaire and checklist.

You may feel uncomfortable asking for personal health information from some family members, but it's important to try. Pick a time when you're less likely to get interrupted so your discussion can be more relaxed. And, remember, older relatives (and even younger relatives) may not use the same health terms as you do, so be aware to listen for clues about how they might describe a relative's behavior or health history. For example, "Grandmother always spent about a week in bed in the dark each month," could indicate that she suffered from menstrual migraines.

The information you gather will help you and your health care provider determine what health problems you may be at increased risk for in the future so that you can take action today to lower those risks. At HealthyWomen, we want you to live the longest, healthiest life possible. This *Family Medical History Questionnaire* can help you do just that.

ALL ABOUT YOU

<table>
<tr>
<td>
Your name:
Date of birth:
Blood type:
Ethnic origin:

Known health problems: Onset age:

❑ Alcohol and/or drug abuse
❑ Allergies
❑ Asthma
❑ Cancer If yes, what kind? ________________
❑ Depression
❑ Diabetes
❑ Heart disease
❑ High blood pressure
❑ High cholesterol
❑ Mental Illness
❑ Stroke
❑ Other ________________________________
❑ Other ________________________________
Do you smoke? ❑ Yes ❑ No
If yes, cigarettes smoked per day: ___________________
If yes, totals years as a smoker: ___________________

How often do you experience stress: ___________________

Do you get regular physical activity? ❑ Yes ❑ No
If yes, how often? ______________________________________

Is your diet healthy and balanced? ❑ Yes ❑ No
</td>
<td>
List any questions or concerns you may have about your medical history:

List any lifestyle or environmental factors related to your health and wellness:

Do you take risks with your health, such as, abuse drugs and alcohol, drive over the speed limit, not wear a seat belt or have multiple sexual partners or unprotected sex?
❑ Yes ❑ No If yes, please describe:
</td>
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ALL ABOUT YOUR PARENTS

Fill out the forms below with your biological (birth) parents' information (living and deceased).

Name: Relationship: Date of birth: Blood type: Ethnic origin:	Name: Relationship: Date of birth: Blood type: Ethnic origin:
Known health problems: Onset age:	Known health problems: Onset age:
❑ Alcohol and/or drug abuse ❑ Allergies ❑ Asthma ❑ Cancer If yes, what kind? ______________________________ ❑ Depression ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ High cholesterol ❑ Mental Illness ❑ Stroke ❑ Other ____________________ ❑ Other ____________________ ❑ Other ____________________	❑ Alcohol and/or drug abuse ❑ Allergies ❑ Asthma ❑ Cancer If yes, what kind? ______________________________ ❑ Depression ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ High cholesterol ❑ Mental Illness ❑ Stroke ❑ Other ____________________ ❑ Other ____________________ ❑ Other ____________________
Does he or she smoke? ❑ Yes ❑ No	Does he or she smoke? ❑ Yes ❑ No
Is he or she deceased? ❑ Yes ❑ No If yes, at what age? ________________ If yes, of what cause? ________________	Is he or she deceased? ❑ Yes ❑ No If yes, at what age? ________________ If yes, of what cause? ________________
List any questions or concerns you may have about their medical history:	List any questions or concerns you may have about their medical history:

ALL ABOUT YOUR SIBLINGS

Fill out the forms below with your siblings' information (living and deceased).

Name:
Relationship:
Date of birth:

Known health problems: Onset age:

- ❑ Alcohol and/or drug abuse
- ❑ Allergies
- ❑ Asthma
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Mental Illness
- ❑ Stroke
- ❑ Other ___________________
- ❑ Other ___________________
- ❑ Other ___________________

Does he or she smoke? ❑ Yes ❑ No

Is he or she deceased? ❑ Yes ❑ No
If yes, at what age? ___________________
If yes, of what cause? ___________________

List any questions or concerns you may have about their medical history:

Name:
Relationship:
Date of birth:

Known health problems: Onset age:

- ❑ Alcohol and/or drug abuse
- ❑ Allergies
- ❑ Asthma
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Mental Illness
- ❑ Stroke
- ❑ Other ___________________
- ❑ Other ___________________
- ❑ Other ___________________

Does he or she smoke? ❑ Yes ❑ No

Is he or she deceased? ❑ Yes ❑ No
If yes, at what age? ___________________
If yes, of what cause? ___________________

List any questions or concerns you may have about their medical history:

Name:
Relationship:
Date of birth:

Known health problems: Onset age:

- ❑ Alcohol and/or drug abuse
- ❑ Allergies
- ❑ Asthma
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Mental Illness
- ❑ Stroke
- ❑ Other ___________________
- ❑ Other ___________________
- ❑ Other ___________________

Does he or she smoke? ❑ Yes ❑ No

Is he or she deceased? ❑ Yes ❑ No
If yes, at what age? ___________________
If yes, of what cause? ___________________

List any questions or concerns you may have about their medical history:

ALL ABOUT YOUR GRANDPARENTS

Fill out the forms below with your paternal grandparents' information (living and deceased).

<table>
<tr>
<td>
Name:
Relationship:
Date of birth:
Ethnic origin:

Known health problems: Onset age:

❑ Alcohol and/or drug abuse
❑ Allergies
❑ Asthma
❑ Cancer
If yes, what kind?
____
❑ Depression
❑ Diabetes
❑ Heart disease
❑ High blood pressure
❑ High cholesterol
❑ Mental Illness
❑ Stroke
❑ Other ______________
❑ Other ______________
❑ Other ______________

Does he or she smoke? ❑ Yes ❑ No

Is he or she deceased? ❑ Yes ❑ No
If yes, at what age? ______________
If yes, of what cause? ______________

List any questions or concerns you may have about their medical history:
</td>
<td>
Name:
Relationship:
Date of birth:
Ethnic origin:

Known health problems: Onset age:

❑ Alcohol and/or drug abuse
❑ Allergies
❑ Asthma
❑ Cancer
If yes, what kind?
____
❑ Depression
❑ Diabetes
❑ Heart disease
❑ High blood pressure
❑ High cholesterol
❑ Mental Illness
❑ Stroke
❑ Other ______________
❑ Other ______________
❑ Other ______________

Does he or she smoke? ❑ Yes ❑ No

Is he or she deceased? ❑ Yes ❑ No
If yes, at what age? ______________
If yes, of what cause? ______________

List any questions or concerns you may have about their medical history:
</td>
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</table>

ALL ABOUT YOUR GRANDPARENTS

Fill out the forms below with your maternal grandparents' information (living and deceased).

Name: Relationship: Date of birth: Ethnic origin: Known health problems: Onset age: ❑ Alcohol and/or drug abuse ❑ Allergies ❑ Asthma ❑ Cancer If yes, what kind? ____________________ ❑ Depression ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ High cholesterol ❑ Mental Illness ❑ Stroke ❑ Other ____________ ❑ Other ____________ ❑ Other ____________ Does he or she smoke? ❑ Yes ❑ No Is he or she deceased? ❑ Yes ❑ No If yes, at what age? __________ If yes, of what cause? __________ List any questions or concerns you may have about their medical history:	Name: Relationship: Date of birth: Ethnic origin: Known health problems: Onset age: ❑ Alcohol and/or drug abuse ❑ Allergies ❑ Asthma ❑ Cancer If yes, what kind? ____________________ ❑ Depression ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ High cholesterol ❑ Mental Illness ❑ Stroke ❑ Other ____________ ❑ Other ____________ ❑ Other ____________ Does he or she smoke? ❑ Yes ❑ No Is he or she deceased? ❑ Yes ❑ No If yes, at what age? __________ If yes, of what cause? __________ List any questions or concerns you may have about their medical history: