

FAMILY HISTORY (IMMEDIATE RELATIVE)

Name	Age	Major Medical Problems	Age, or Age if Deceased
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Sibling #1			
Sibling #2			
Sibling #3			
Sibling #4			
Sibling #5			
Sibling #6			
Children #1			
Children #2			
Children #3			
Children #4			
Children #5			
Children #6			
Children #7			
Other relative #1			
Other relative #2			
Other relative #3			

Current Medications (include over-the-counter and home remedies)

- | | |
|-----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |
| 11. _____ | 12. _____ |

Allergies (Please mention type of reaction)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Patient's Signature _____ **Date** _____