

Family Medical History

Instructions: Please mark all that apply and include AGE OF ONSET inside the box

Please take the time to speak with your family members and bring this *completed* form to your next scheduled visit. If you have questions or need help filling out this form please contact Colchester Family Practice at (802) 847-2055.

Name: _____

DOB: _____

	Age (current or at death)	Deceased? (Y/N)	Cause of Death	High Blood Pressure	High Cholesterol	Diabetes (Type 2)	Heart Disease	Stroke or Cerebral Aneurysm	Cancer (Colon)	Cancer (Breast)	Cancer (Ovarian)	Cancer (Prostate)	Cancer (other)	Osteoporosis	Arthritis (OA or RA)	Asthma	Blood Clots or Bleeding Disorder	Thyroid Disease	Depression/Anxiety	Alcoholism or Substance Abuse	Other	Additional or clarifying information (may include diet, smoking, exercise, or important medical treatments received)	
(Example)	72y	Y	Stroke			X 62y	X 55y															Heart attack age 55-1 stent placed Smoker (~30 years)	
Mother																							
Father																							
Siblings																							
Children																							
Maternal Grandmother																							
Maternal Grandfather																							
Paternal Grandmother																							
Paternal Grandfather																							
Maternal Aunts																							
Maternal Uncles																							
Paternal Aunts																							
Paternal Uncles																							

Certain diseases are genetically linked or more common in specific racial or ethnic groups; please circle any that apply to your family's ethnicity:

Ashkenazi Jew Mediterranean Southern or Southeast Asia Chinese African-American Northern European