Family History

Patient Information (adult):

Today's Date: ____

Name: ____

Email: ____

Birthdate: ____

Please include information about your mother, father, brothers, sisters, and grandparents. Please list all family members who have had these ailments.

Family Ailments:

Alcoholism / Drugs: ______________________________

Allergies: ____________________________________

Anemia: _____________________________________

Arthritis / Gout: _______________________________

Asthma: _____________________________________

Bleeding problems: ______________________________

Cancer: _____________________________________

Depression: ___________________________________

Diabetes: ____________________________________

Eczema / Psoriasis / Rashes: _______________________

Epilepsy: ____________________________________

Frequent Infections: ____________________________

Glaucoma: ___________________________________

Heart trouble: _________________________________

Hepatitis: ____________________________________

High Blood Pressure: ___________________________

Kidney Problems: ______________________________

Mental Illness: _________________________________

Migraines: ___________________________________

Polio: _______________________________________

Pneumonia: ___________________________________

Prostate Problems: _____________________________

Rheumatic Fever: ______________________________

Stomach problems: _____________________________

Stroke: ______________________________________

Thyroid problems: ______________________________________

Tuberculosis: ____

Venereal Diseases (herpes, syphilis, gonorrhea, etc.):

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Please resubmit to Dr. Henry Kostecki at hkostecki@gmail.com

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