

FAMILY HISTORY: _____ UNKNOWN _____ I AM ADOPTED

Place a check in the appropriate boxes. Please specify if Alive (A) or Deceased (D). If deceased, please CIRCLE the check mark associated with cause of death and WRITE IN THE AGE OF DEATH.

	A	D	First Name	Cancer (type)	Heart disease	Diabetes	Alzheimers	Mental Illness (type)	Other
Father									
Mother									
Brother									
Brother									
Brother									
Sister									
Sister									
Sister									
Son									
Son									
Son									
Daughter									
Daughter									
Daughter									
Dad's Dad									
Dad's Mom									
Mom's Dad									
Mom's Mom									
Uncle									
Aunt									

GENERAL HEALTH MAINTENANCE

Test or Exam	Month and Date of LAST TEST OR EXAM
Complete Physical	
Colonoscopy	
Mammogram	
Pap Smear	
PSA (prostate specific antigen)-Men only	
Eye exam	
Foot exam (if diabetic)	
EKG	
Chest X-ray	
Heart Scan	
Skin Exam	

PLEASE USE THIS SPACE FOR ADDITIONAL COMMENTS, MEDICATIONS, OR ILLNESSES