FAMILY MEDICAL HISTORY

Please list any of your close relatives: (sisters, brothers, parents, grandparents, children, uncles, aunts) that has or has had any of the following diseases:

- AIDS/HIV _____
- Allergies _____
- Angina pectoris (heart related chest pain) or heart attack _____
- Bleeding disorders _____
- Cancer _____
- Diabetes _____
- Emphysema _____
- Glaucoma _____
- Heart Disease _____
- Hepatitis _____
- Kidney disease _____
- Liver Disease _____
- Migraine headaches _____
- Multiple Sclerosis _____
- Osteoporosis _____
- Parkinson's Disease _____
- Polio _____
- Psychiatric disease _____
- Rheumatoid Arthritis _____
- Stroke _____
- Tuberculosis _____
- Venous thrombosis (blood clots) or atherosclerosis _____
- Other chronic diseases _____

* If any of your close relatives has died from any of the above, at which age did they die?

_____

_____

PRINT PATIENT NAME: _____

Patient Signature _____ Date _____

********************************Office Use only************************************

Provider Signature: _____ Alex Janis DC