Adult Medical Questionnaire

FAMILY HISTORY: For each member of your family, check the boxes for:

1. Their present state of health
2. Any illnesses they have had

*(Note: Except for **spouse**, Family refers to **blood** or **natural** relatives.)* **PRINT NAMES BELOW**	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Spouse:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal relatives (in each box, write in how many affected with condition):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal relatives (in each box, write in how many affected with condition):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐