

NEIL A. PATTERSON, M.D., P.A.
Family Medical History

Patient Name _____ DOB _____ Date Completed _____

Please place a check mark below any condition which applies to any family member or mark "unknown". For Cancers please specify in box what type, if known.

<u>Family Member</u>	<u>L= Living</u> <u>D= Deceased</u> <u>U= Unknown</u>	<u>Year</u> <u>of</u> <u>Birth</u>	<u>Diabetes</u>	<u>High Blood</u> <u>Pressure</u>	<u>Heart Disease</u>	<u>Mental Health</u> <u>Alcohol/Substance</u> <u>Abuse</u>	<u>Cancer</u>	<u>History</u> <u>Unknown</u>
Mother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Gr. Mother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Gr. Father			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Gr. Mother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Gr. Father			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter(s)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son(s)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Brothers _____ # Sisters _____ # Sons _____ # Daughters _____