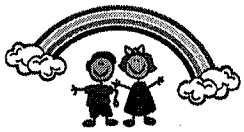

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UPDATED FAMILY MEDICAL HISTORY

Patient Name: _____ DOB: ____/____/____

Siblings: _____

Family History ***Please give as much detail as possible and specify who the affected family members are -*** *M-Mother, F-Father, S-Sibling, *GM-Grandmother, *GF-Grandfather, *A-Aunt, *U-Uncle *note if it is maternal or paternal side*

☐ Allergies / Asthma / Eczema _____

☐ Deafness / ENT problems _____

☐ Eye problems _____

☐ Mental illness _____

☐ Learning problems / ADHD _____

☐ Abuse / Alcohol / Drug / Smoking _____

☐ Cancer _____

☐ Heart attack / Stroke / Sudden death _____

☐ Hypertension / High Cholesterol _____

☐ Thyroid problems / Diabetes / Obesity _____

☐ Seizures / Migraine headaches _____

☐ Anemia / Bleeding disorders _____

☐ Stomach / GI _____

☐ Infectious disease (Ex. TB) _____

☐ Other: _____

Reviewed by: _____ Date: _____