

**Steinmetz Medical Associates, PC
Family Medical History Form**

Name (First, Middle, Last) _____

Date of Birth _____ Sex _____ Ethnicity _____

Current Physician(s) _____

Please list the current status of your immediate family members.

Grandparents Maternal/ Paternal	Alive / Deceased	Age (Now or at Death)	Comments / Cause of Death
Maternal G-Mother			
Maternal G-Father			
Paternal G-Mother			
Paternal G-Father			

Parents	Alive / Deceased	Age (Now or at Death)	Comments / Cause of Death
Mother			
Father			

Siblings	Alive / Deceased	Age (Now or at Death)	Comments / Cause of Death

Name (First, Middle, Last) _____

Please indicate all known health conditions that apply to members of your immediate family, including parents, grandparents and siblings, below:

Health Condition	Family Member(s)	Age of Onset/ Type
Alzheimer's Disease		
Arthritis		
Asthma / Allergies		
Aneurysm		
Blood Clots		
Blood Disorder(s)		
Cancer:		
Breast		
Colon		
Lung		
Prostate		
Other		
Diabetes		
Epilepsy		
Eye Condition(s)		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Leg Cramps/ Foot Ulcer		
Lung Disease		
Osteoporosis		
Psychiatric Disorder		
Seizures/ Epilepsy		
Smoking		
Stroke		
Thyroid Disorder		
Tuberculosis		
Ulcer		

List any other illnesses, surgeries, treatments or conditions, including those related to military service:
