



Family Health History Form

Recording your family health history is an important way to take control of your own health and to help you understand your risks for certain diseases and conditions. A Family Health History Form is a tool that can help you make more informed choices about diet, exercise and other lifestyle decisions. It can also help you understand your risks that are not related to choice but are instead passed on from generation to generation. Families affect their relatives' health through the genetic transmission of vulnerability to illness and disease.

By completing a family health history form, you can assist your health care provider with your long-term health planning. It may even impact the treatments and screenings that your doctor recommends for you. For example, if your doctor knows that several members of your family have had or have been treated for a disease or condition, such as breast cancer or diabetes, they may screen you more frequently. By diagnosing diseases and conditions earlier, your health can be better managed and might have better outcomes.

On the next page is a Family Health History Form. Please take a look at it and talk about it with your loved ones. If there are diseases and conditions that you are unfamiliar with or do not know about, make note and remember to ask your doctor during your next appointment. During that visit, please share with your physician that you are a caregiver as well. Your doctor might have some resources to help you with your responsibilities.

Once you have completed it, the Family Health History should be shared with each family member's health care provider. Please remember, having family members with a disease or condition does not mean that you will develop the disease or condition too. With proper screening and prevention measures you can take control and possibly even reduce your risk.

How to complete the Family Health History Form:

- 1) Place a "check mark" in each box next to the disease or risk factor that affects each family member. You may need to contact family members to be able to answer each section.
- 2) Complete a box for all family members, including those who have died
- 3) Copy the form and share this information with your health care provider and encourage family members to do the same.

Family Health History

Legend

Stroke.....Stroke
 Heart Disease.....Heart D.
 Prostate Cancer.....Prost.C.
 Cancer.....Cancer
 Diabetes.....Diab.
 High Blood Pressure.....HBP
 High Cholesterol.....H. Chol.
 Smoker.....Smoker

Mother
Stroke..... <input type="checkbox"/>
Heart D..... <input type="checkbox"/>
Cancer..... <input type="checkbox"/>
Diab..... <input type="checkbox"/>
HBP..... <input type="checkbox"/>
H. Chol..... <input type="checkbox"/>
Smoker..... <input type="checkbox"/>
Other: _____

Father
Stroke..... <input type="checkbox"/>
Heart D..... <input type="checkbox"/>
Prost C..... <input type="checkbox"/>
Cancer..... <input type="checkbox"/>
Diab..... <input type="checkbox"/>
HBP..... <input type="checkbox"/>
H. Chol..... <input type="checkbox"/>
Smoker..... <input type="checkbox"/>
Other:_____

Spouse

Stroke..... <input type="checkbox"/>
Heart D..... <input type="checkbox"/>
Prostate C.... <input type="checkbox"/>
Cancer..... <input type="checkbox"/>
Diab..... <input type="checkbox"/>
HBP..... <input type="checkbox"/>
H. Chol..... <input type="checkbox"/>
Smoker..... <input type="checkbox"/>
Other:_____

ME
Stroke..... <input type="checkbox"/>
Heart D..... <input type="checkbox"/>
Prost C..... <input type="checkbox"/>
Cancer..... <input type="checkbox"/>
Diab..... <input type="checkbox"/>
HBP..... <input type="checkbox"/>
H. Chol..... <input type="checkbox"/>
Smoker..... <input type="checkbox"/>
Other:_____ <input type="checkbox"/>

Brother / Sister	Brother / Sister	Brother / Sister	Brother / Sister
Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>
Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>
Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>
Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>
Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>
HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>
H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>
Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>

Son / Daughter	Son / Daughter	Son / Daughter	Son / Daughter	Son / Daughter
Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>
Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>	Heart D..... <input type="checkbox"/>
Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>	Prost C..... <input type="checkbox"/>
Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>
Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>	Diab..... <input type="checkbox"/>
HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>	HBP..... <input type="checkbox"/>
H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>	H. Chol..... <input type="checkbox"/>
Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>	Smoker..... <input type="checkbox"/>

Anything else?